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People's Charter For Health (2000)

People's Charter For Health

People's Health Movement - Join Us - Endorse the Charter
We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the *People's Charter for Health*.

Preamble
Vision
The Health Crisis
Principles of the People's Charter for Health
A Call for Action

Health as a Human Right
Tackling the Broader Determinants of Health
Economic Challenges

Social and Political Challenges
Environmental Challenges
War, Violence, Conflict and Natural Disasters
A People-centred Health Sector
People's Participation

PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed.

This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives.

There are more than enough resources to achieve this vision.

The HEALTH CRISIS

"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us."

(A voice from Central America)

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International

Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.

Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

4. The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
5. The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
6. Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
7. The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
8. Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.

A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

This Charter calls on people of the world to:

9. Support all attempts to implement the right to health.
10. Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
11. Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
12. Fight the exploitation of people's health needs for purposes of profit.

TACKLING THE BROADER DETERMINANTS OF HEALTH

Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations.

Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.

This Charter calls on people of the world to:

13. Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
14. Demand the cancellation of Third World debt.
15. Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
16. Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
17. Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
18. Demand that national governments act to protect public health rights in intellectual property laws.
19. Demand the control and taxation of speculative international capital flows.
20. Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
21. Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

Social and political challenges

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures. Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

This Charter calls on people of the world to:

22. Demand and support the development and implementation of comprehensive social policies with full participation of people.
23. Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
24. Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
25. Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
26. Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
27. Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
28. Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
29. Oppose sex tourism and the global traffic of women and children.

Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

This Charter calls on people of the world to:

30. Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
31. Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
32. Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
33. Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
34. Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
35. Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
36. Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
37. Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.

38. Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

War, violence, conflict and natural disasters

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

This Charter calls on people of the world to:

39. Support campaigns and movements for peace and disarmament.
40. Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
41. Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
42. Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
43. Demand the end of occupation as one of the most destructive tools to human dignity.
44. Oppose the militarisation of humanitarian relief interventions.
45. Demand the radical transformation of the UN Security Council so that it functions democratically.
46. Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
47. Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.
48. Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
49. Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

This Charter calls on people of the world to:

Oppose international and national policies that privatise health care and turn it into a commodity.

Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.

Pressure governments to adopt, implement and enforce national health and drugs policies.

Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.

Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.

Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.

Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.

Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in their communities, and are encouraged to work with and respect the community and its diversities.

Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.

Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.

Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

This Charter calls on people of the world to:

49. Build and strengthen people's organisations to create a basis for analysis and action.
50. Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
51. Demand that people's organisations be represented in local, national and international fora that are relevant to health.
52. Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a *People's Charter for Health*.

The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000.

The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health moment can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the *People's Charter for Health*.

PHM Secretariat,
e-mail: secretariat@phmovement.org

Amendment

After the endorsement of the PCH on December 8, 2000, it was called to the attention of the drafting group that action points number 1 and 2 under Economic challenges could be interpreted as supporting the social clause proposed by WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read *to end all kinds of sanctions*. An additional action point number 11 was added concerning natural disasters.

A People's Web: Towards Structures for a People's Health Movement (2001)

TOWARDS FACILITATING STRUCTURES FOR A PEOPLE'S HEALTH MOVEMENT

Principles

- Develop a feeling of belonging to a movement for change.
- Inclusive. We will enable people and organisations with different and diverse backgrounds to be part of the PHM. However we will ensure that a pro-people orientation remains fundamental. (This will sometimes require positive action i.e. for people with disabilities)
- Transparent, democratic and open
- Representative of
  - South/North
  - Genders
  - Ethnicity/Race
  - Emailing and without access to email
  - Different languages as possible
  - Ages/Generations - especially young and older people
- We need to celebrate diversity and encourage and recognize that there are multiple solutions.
- We recognize that Women's access to health often is still unequal and inappropriate and that this needs to be challenged and changed.
- Linking with networks and movements, being complimentary to the work of others and providing a space for others. The PHM places importance on membership organisations, networks and movements with democratic decision making processes. This is key.
- Work based and building on the People's Charter for Health. This is our fundamental common ground.
- Build on collective energies and actions

- Each country in their own way

Assumptions

1. There is a need for a global structure and that this has to be founded, informed and inspired by people's experiences, strategies and visions.

2. The base should be geographical, building on our strengths. The regions of the world should suit us.

3. Our structure should bring together organizations and movements and facilitate exchanges of experiences, information, strategies and actions between them.

4. The focus is not on decision making though this is of course needed

5. The type of organizational structure most appropriate to the development and strengthening of the People's Health Movement is not pyramid shaped but circular.

THE NEW STRUCTURE

Circles

The **Circles** are the foundation of our structures.

Circles are created and made up of people who are representatives and activists from organizations and are people committed to working on the issue or activity that is the focus of the circle.

Circles are open and not closed.

Circles can have autonomy to agree on their most appropriate ways of working.

Circles should develop and agree plans for their work and share these as appropriate.

Circles will intersect.

Circles, when formed, will elect a link person(s) to link to other appropriate circles.

Types of circles

Circles are envisaged at different **geographical** levels and for different areas of work – **Working Circles.**

Geographical Circles are envisaged at a minimum of three levels

1. National People's Health Movement Circles
2. Regional People's Health Movement Circles
3. International People's Health Movement Circles

Different areas of work can generate different **Working Circles**. These are also envisaged to exist at the three geographical levels when appropriate. Some may first be established at the international level. As activity and interest is developed then connected regional and or national circles might be developed.

A member of a working circle would come from and be on a national or regional circle. They would be the link person for that area of work or activity on their circle.

Members of working circles have the obligation and responsibility to share their work with other members of their national or regional circle.

Linking of Circles

One of the most important parts of the structure is the way in which circles link together. Elected members of each circle will be the link person to other appropriate circles. This could be between two different working circles or between a working and geographical circle. The linking has many roles and responsibilities. It is key to enabling the People's Health Movement to be more comprehensive and to making sure that the geographic and working circles share their ideas and activities. The links can also enable us to join and co-operate with other movements and networks.

Many individuals and organisations involved in the PHM across the world are already involved in specific advocacy work. The PHM aims not only to generate credible people centred alternatives but also to recognise, collate and endorse such alternatives that emerged before and after the People's Health Assembly 2000 and that will emerge in the future. Some are linked to the PHM and others are independent. The new structure ensures that they have a place for this to continue, to be able to share this better with other activists and to link with other people and organisations engaged in complementary activity.

Geographical Regions

The **initial regions** are based on areas where the People's Health Movement has some strength with two exceptions. These are West Africa and China, where we plan to have some strength in due course.

The initial regions proposed are;

1. India
2. South Asia, not including India
3. South-East and East Asia, not including China
4. China
5. Pacific, Australia and New Zealand
6. Middle East and North Africa
7. West Africa
8. East and Central Africa
9. Southern Africa
10. Europe
11. South America
12. Central America including Mexico and the Caribbean
13. North America

This is not a complete or perfect regionalization of the world and through discussion, consultation and evolution we will be able to evolve a regionalization which reflects what each region feels is a viable and a positive contribution to the People's Health Movement. National Circles would need to decide on what is the most suitable and appropriate region for them.

Some countries may feel it necessary and appropriate to establish regional, province or state level circles.

National circles would elect link person(s) with a Regional People's Health Movement Circle.
One elected representative from each of these Regional People's Health Movement Circles will be a representative for the International People's Health Movement Circle.

Secretariat

It is proposed that there is a Secretariat for the International People's Health Movement. The Secretariat will play an important role in catalysing and facilitating the different circles and their inter-relationships. The Secretariat is likely to rotate after an agreed period if this was felt to be desirable and feasible. It is expected that the Secretariat will move every few years. It would not be permanently in one place. The role and functions of the Secretariat would need to be agreed.

International People's Health

Movement Circle

The International People's Health Movement Circle will be the reference body for the Secretariat.

It is also proposed that the co-ordinator or facilitator of the Secretariat for the International People's Health Movement will be representative on the International People's Health Movement Circle. This will mean that the initially the International People's Health Movement Circle has a minimum of fourteen members.

It will be the right of the International People's Health Movement Circle to increase this if appropriate.

Ways of working would be agreed for the International People's Health Movement Circle.

It may be desirable for the for the International People's Health Circle to elect a smaller group who would be a reference group for the secretariat on certain agreed issues.

Working Circles

a) Working Circles- to enable the development and strengthening of the PHM

Working Circles could be developed for activities that are key to the development and strengthening of the People's Health Movement itself. These will generally begin as International Working Circles.

Initially these are proposed to be a minimum of

a. People-centered communication
b. Publications
c. Communication for advocacy
d. Charter – popularizing, translating and promoting
e. Representation – Developing PHM positions and agreeing meeting attendance etc.
f. Resources, Funding and Budget
g. Developing and updating the website
h. Network liaison development
i. Relationship with and lobbying of the WHO

b) Working Circles – for policy and lobbying work

Working circles could also be developed for specific areas of policy and lobbying work. Some of these might be of a short duration and related to an activity others may be on-going. This is an open ended list. If there is the commitment and energy to establish and contribute. These might initially include

1. Health and Militarization
2. Trafficking of Women
3. Violence against Women
4. Anti-Privatization
5. PRSPs and Health
6. GATS and Health
7. Women's access to health
8. Rational drugs
9. Macro-economics and Health
10. Good examples of people-centered approaches to Primary Health Care
11. Medical Education and Health/Health Human Power Education
12. Indigenous People and Health rights

Etc. etc. etc. This list will be organic and based on people and organizations ability and commitment to do things.

Many Working Circles might be first established at the International level

In some regions for some working circles, regional circles may be appropriate and desirable.

For some working circles, national circles may be appropriate and desirable.

Each level of working circle will need a focal link person/organization as outlined above. This person/organization will be elected by the working circle. It is desirable for this role to rotate at a frequency agreed by the circle.

The International People's Health Movement Circle will need to decide on the most appropriate ways of relating to and linking with both the Working Circles- to enable the development and strengthening of the PHM and the Working Circles – for policy and lobbying work.

Specific attention will be given to the ways that the circles work and interact and outlining the principles they can work with in more detail. It may be appropriate to develop briefings on possible ways to establish and work in circles.

Developing PHM positions and responses

Position papers and documents supported by the PHM should be backed by a process of collective endorsement. Though individuals and organisations are encouraged to take public positions under their own names, a PHM position should evolve more collectively. Specific process for this will be developed by the Representation Working Circle.

Accountability and Responsibility

As stated above, a key concept in the working circles and the geographical circles is **accountability back to a constituency**. This may also be important for members of National People's Health Movement Circles as they may be there from and on behalf of certain constituencies.

The joining of these interlinked circles will create a

People's Web.

This is the end of the new structure

The timetable and process for the taking forward the new structure

From **December 2001** the agreed new structure will be taken forward.

It is proposed that initiators will be approached by the Secretariat to bring people together to establish circles. This is a very temporary role. Once initiated the members of the Circle will elect their co-ordinator and their link person to other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate. Circles may include a number of link people to a variety of circles.

The established circles will liaise with the Secretariat through the Link person.

The National People's Health Movement Circles. The members of the National PHM Circle will elect their co-ordinator and their link person to Regional PHM Circles and other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate,

The Regional People's Health Movement Circles. The members of the Regional PHM Circle will elect their co-ordinator and their link person to International PHM Circle and other appropriate circles. The Circle co-ordinator and link person might be the same person in some cases and different people in others. It will be up to the circle to decide what is appropriate

The International PHM Circle will adopt statutes to operate under when it is initiated.

Timetable

The process of establishing National PHM Circles is of course different in each country. Some already have strong national committees, others are in the process of forming them and some have limited contact with the PHM. It is proposed that National groups initiate National PHM Circles between **December 2001 and the end of March 2002.**

The National PHM Circles that are initiated by then The Secretariat will work with National groups to initiate Regional PHM Circles between **April 2002 and the end of August 2002**. Some Regional PHM Circles will be able to be initiated before this period.

It is planned for the first International PHM Circle meeting to take place by the end of **October 2002** at the latest.

Clearly new National and Regional will continue to be established and they will be able to link with established Circles as they are able.

Interim arrangements

The International PHM Circle will take over the responsibility as a reference body for the Secretariat from its initial meeting.

The Secretariat will require a reference body in the interim period. The aim is to be consistent with the proposed changes and for them to not contradict what will be developed over the next year.

As a result it is proposed to establish a **Secretariat Support Circle**. This will be composed of the elected link people in the Working Circles initiated to enable the development and strengthening of the PHM.

Initially these have been proposed to be a minimum of 9 Working Circles

- People-centered communication
- Publications
- Communication for advocacy
- Charter – popularizing, translating and promoting
- Representation – Developing PHM positions and agreeing meeting attendance etc.
- Resources, Funding and Budget
- Developing and updating the website
- Network liaison development
- Relationship with and lobbying the WHO

In electing the link people for these Working Circles people should be aware of the additional responsibility.

Other Working Circles will be expected to share their plans for work and activities with the Secretariat during this period.

As a result the Secretariat Support Circle will continue as an interim reference body.

Savar
3rd December 2001

Organisational Structures from Steering Group of November 2002

People's Health Movement — Organisational Structure And Framework — Some Guidelines

A. BACKGROUND

1. Two years since the historic People's Health Assembly at the Gonoshasthaya Kendra (GK) campus at Savar (Bangladesh) in December 2000, the People's Health Movement has evolved as a dynamic and responsive voice of the voiceless. Further, it has put a challenge at the academic and intellectual level by challenging anti-health and anti-poor policies at the International level.

2. The first Core Group meeting that was held at the GK campus in the last week of November 2001, brought back nostalgic memories and the collective energy that was demonstrated at the venue of the PHA 2000. This core group that had facilitated the global process and the secretariat of the People's Health Movement reflected on the road the movement has traveled since PHA 2000 and evolved some strategies to move forward.

3. People's Health Movement's Core Group meeting at Savar (GK: 20th22nd Nov 2002) reviewed arid endorsed the strategies once again and evolved a plan for synergic and decentralized action towards this new framework. The following are the important guidelines that emerged about the process, organisation structure and working principles of people's health movement and its various circles.

B. STRUCTURE OF PHM

PHM should be an enabling process and decentralised actions should be the building block. Any structure for PHM should be based on this foundation and should ensure synergy.

The challenge for a growing movement is to ensure how we link and relate with the existing structures of other networks and movements to ensure synergy

There should not be any centralized decision making process.

Circles and other constituents of the movement should be encouraged to take decisions and move on and the secretariat should facilitate the pace and spirit with no bureaucracy

Facilitation and empowerment should be the objective of geographic and working regional circles

The structure of the PHM will be intersecting circles of two types

Geographical circles

(a) Regional circle (13 Regions, see table)

(b) National circle (92 +)

(c) Local circle (These could be at village / town I city / district / state level — depending on situation)

Each region will consist of a coalition of national circles. National circles depending on the size of the country would consist of state circles and state circles could consist of district circles and so on.

Issue based working circles (membership of this would be drawn from different geographical areas on a purely voluntary basis

Secretariat

Regions will host the secretariat from time to time

The secretariat will coordinate, facilitate the working together of all the geographical and issue based circles

Secretarial support group

Steering group

Earlier called the Core group, this 23 member group will steer the decision making process of the movement, particularly the international and collective initiatives

Funding group: Helps in the decision making process of funding, finances etc.,

Communication and media group: Helps and supports the secretariat on all the communication and media related work

Geographical Circles

General working principles:

13 geographical circles have been formed. Generally a network organization would be the host of a geographical circle.

Identification of groups! networks in regions is important (not only individuals or NGC's) to provide extra support to consolidate and facilitate PHM activities

Circles should be inclusive and help to reach out to more people who are working on issues that are important to PHM. This will be one way to expand the reach and domain of the PHM as a movement

The evolution of geographical circles at country and state levels is a gradual process

Each geographical circle will have a facilitator elected from the region, country or state. S/he must have the following capacities to enable the movement building process

People and organizations and networks need to be constantly identified by the Secretariat and the steering group to facilitate activities in locations where PHM doesn't have any presence. The constituting bodies of PHM, who may have their presence or links in such places could take the initial responsibility to identify facilitators in such places. Eg: IPHC in Americas, Australia and ACHAN in South East Asia, WGNRR in East Africa, HAI, CI and TWN in other regions. Focal points from neighbouring regions could help the PHM secretariat in this process

Responsibilities of Facilitators and Link Persons

Facilitator

• Should be representative — of a group / network in the region! country

• Must have an understanding of the ground reality of the region I country and policies

• Must have skills of motivation, networking, and capacities to communicate, accounting, computer etc.,

• Must be responsible to a parental organization! network for support

• Must be inclusive and able to dialogue with a wide cross section of networks and individuals

Link person

The initial selected nominated contact in a geographical area- country or region will be called a link person. When the group increases in size and representation then the facilitator should be elected democratically for a period of 1-2 years

Issue Circles

An issue circle will facilitate the initiation of dialogue on the specialized issues

Each issue circle will have a Convenor, who will facilitate the sharing, perspective building and communication process.

S/he will strengthen the work done by individual members of the circle

It will help PHM understand such issues better and at times take positions and provide input to the PHM process on specific issues and give suggestions about who could represent PHM when PHM gets invited for events on these specific issues

S/he will be responsible mainly to the circle members and to the steering committee and PHM secretariat

Link person

The initial selected or nominated contact in a geographical area- country or region. When the group increases in size and representation then the convenor will be elected democratically for a period of 1-2 years. Convenorship could rotate within the group.

C. SECRETARIAT

The Secretariat will be hosted by different regions in rotation

Some of the activities will be retained at the previous secretariat

2-3 years will be the period for the secretariat to be in one place

Use of a letterhead renamed as People's Health Movement reflecting steering group of networks will be promoted

The secretariat will be supported by a steering group in the decision making process

Secretarial support group will be evolved for communications and publications, media, PHM exchange, funding etc.,

Functions

Facilitation and empowerment of PHM vision

External I Internal communication in PHM between member and circles

Management of collective initiatives and events

To designate planning, monitoring and evaluation

Fund raising and financial management

Working with members, donors, facilitators, contact points etc.,

Minimum needs for smooth functioning of the Secretariat

Full time Secretariat coordinator (on deputation to PHM secretariat from hosting organisation)

A communication officer (website) capable of dealing with communication challenges

A technical officer to help the coordinator (could be short term volunteers or short term linkage)

A person for accounts

Some office infrastructure, computer, telephone, fax, basic library, office space drawn from hosting organization and supported by PHM budget

Secretarial support group

Steering committee

A steering committee consisting of the 8 networks and the 13 regional centers along with the incoming and outgoing coordinators help in collective decision making. It will meet at least once a year to take stalk of the evolution and challenges of the movement and plan responses and strategies

It will also constantly identify regional / international events that could be used as strategic opportunities for both PHM participation and smaller group steering committee meetings and dialogue

A steering committee discussion group (yahoo group) will be established to help the secretariat keep all members involved and informed in all the key decisions

Funding group

A 6 member funding group assists the secretariat in financial and funding matters helping to evolve the project proposals, budget, logical frame and identifying and dialoguing with potential partners on behalf of PHM

Communications and media circle

Will facilitate both internal and external communication and thereby contributing to the expansion of the decentralized movement.

Website and related communication activities and through this increase the visibility of the movement

E-mail communication with usage of PHM signatures

Issue of timely press releases and publication of the same

Devising methods to overcome the digital divide

Launch of campaigns (for eg. Million signature campaign)

Regular press releases on health issues of global concern

Publications and PHM resource centre

The GK Savar centre, which hosted the secretariat for the first two years will continue as a PHM resource centre

It will bring out a Newsbrief and related newsletters to highlight the activities during a specified period (keeping the digital divide in sight)

It will publish the policy/ background papers and in coordination with organizations I individuals from the regions

A small editorial group would support this activity.

Sometimes a small additional group would be formed for a specific publication

The centre will also keep track of all the publications, handouts, educational and promotional materials that evolved in the PHM

Globally, regionally and at country level

Secretariat — Criteria for selection in a region

Willingness to host the secretariat by the organisation and endorsement by the regional circle

Must have skills in communication, management, finances, project implementation and reporting

Must be inclusive and have skills in networking and advocacy

Must be committed to the PHM vision and the People's Charter for Health

PHM REGIONS

Countries represented at PHA in 2000	**Country contact points established after PHA 2000**	**Countries not represented**
ASIA SOUTH:		
BANGLADESH, NEPAL, PAKISTAN, SRILANKA		(MALDIVES) (BHUTAN)
INDIA WITH 19 STATES		

ANDHRA PRADESH, BIHAR, CHHATTISGARH, DELHI GUJARAT, HARYANA, HIMACHAL PRADESFI, KARNATAKA, KERALA, MADHYA PRADESH, MAHARASHTRAORRISA, PUNJAB, RAJASTHAN, TAMILNADU, TRIPURA, UTTAR PRADESH, WEST BENGAL,	JHARKAND	ARUNACHAL PRADESH, ASSAM, GOA, JAMMU AND KASHMIR, MANIPUR, MEGHALAYA, MIZORAM, NAGALAND, SIKKIM, UTTARANCHAL
CHINA		
CHINA		
ASIA - SOUTH EAST:		
INDONESIA, JAPAN, KOREA, MALAYSIA, MYANMAR, PHILIPPINES, SINGAPORE. THAILAND, VIETNAM. CAMBODIA		(HONG KONG), (LAOS), (BRUNEI), (TAIWAN)
AFRICA – SOUTH		
MOZAM BIQUE, SOUTH AFRICA, ZAMBIA, ZIMBABWE, MAURITIUS		(ANGOLA) (NAMIBIA), (BOTSWANA), (MADAGASCAR), (MALAVI), (LESOTHO) (SWAZILAND)
AFRICA - EAST AND CENTRAL		
KENYA. TANZANIA, UGANDA, SEYCHELLES	CONGO	(ZAIRE). (ETHIOPIA) (SOMALIA) (CENTRAL AFRICAN REPUBLIC) (RWANDA), (BURUNDI),
AFRICA-WEST		
CAMEROON, GHANA. MALI, SENEGAL	TOGO	(NIGERIA), (MAURTITANIA). (NIGER) (CHAD) (SUDAN), (IVORY COAST). (GABON), (GAMBIA), (BENIN), (BURKINA). (GUINEA), (LIBERIA), (SIERRA LEONE)
MIDDLE EAST AND NORTH AFRICA		

EGYPT, IRAN, IRAQ, JORDAN, LEBANON, MOROCCO, PALESTINE. SUDAN, TUNISIA, ARMENIA, TURKEY, AZERBAJAN		(LIBYA), (ALGERIA), (ERITREA) (SYRIA), (SAUDI ARABJA), (QATAR), , (UAE), (KUWAIT, (TURKMENISTAN), (AFGHANISTAN), (ISRAEL), (KAZAKSTAN), (UZBEKISTAN), (KYRGYZSTAN), (TAJIKSTAN), (BAHRAIN), (YEMEN), (OMAN)
PHM – EUROPE		
BELGIUM, DENMARK, FINLAND, FRANCE, GERMANY, GREECE, ITALY, NETHERLANDS, NORWAY, RUSSIA, SWEDEN, SWITZERLAND, UNITED KINGDOM, TURKEY, UKRAINE,		(ICELAND), (IRELAND), (PORTUGAL), (SPAIN), (ANDORRA), (MONACO), (LUXEMBURG), (AUSTRIA), (LIECHTENSTEIN), (SAN MARINO), (VATICAN CITY), (MALTA), (POLAND), (SLOVAKIA). (SLOVENIA), (CROATIA). (YUGOSLAVIA), (BOSNIA - HERZEGOVINA), (MACEDONIA), (BULGARIA), (ROMANIA), (MOLDOVA). (CZECH REPUBLIC), (HUNGARY), (LITHUANIA), (LATVIA), (BELARUS), (ALBANIA), (ESTONIA)
NORTH AMERICA		
CANADA, UNITED STATES OF AMERICA		
CENTRAL AMERICA, MEXICO AND THE CARIBBEAN		
CUBA, DOMINICAN REP. EL SALVADOR, GUATEMALA, JAMAICA, MEXICO, NICARAGUA, COSTA RICA		(PANAMA), (HONDURAS), (BELIZE) (HAITI), (BAHAMAS), (TRINIDAD AND TOBAGO), (ANTIGUA), (DOMINICA), (BARBADOS). (GRENEDA), (ST. KIITS - NEVIS), (ST. (VINCENT AND THE GRENADINES)
SOUTH AMERICA		
ARGENTINA, BRAZIL, CHILE, EQUADOR, PERU, URUGUAY, COLUMBIA,		(VENEZUELA), (GUYANA), (SURINAM) (FR. GUYANA), (BOLIVIA), (PARAGUAY)
AUSTRALIA AND PACIFIC		

AUSTRALIA, FIJI, NEW ZEALAND, PALAU, SAMOA		(MARSHALL ISLANDS), (FED. STATES OF MICRO NESIA), (PAPUA NEW GUINEA), (NAURU), (KIRIBATI), (JONOA), (SOLOMAN ISLANDS), (TUVALU), (VAN,.JATU), (NORTHERN MARIANES)

Guidelines Relevant to PHM Global Secretariat. Source: Extracts from People's Health Movement – Organizational structure and framework – Some Guidelines (2004)

GUIDELINES RELEVANT TO PHM GLOBAL SECRETARIAT

Source : Extracts from People's Health Movement – Organizational structure and framework – Some Guidelines, November 2002 (Updated January 2004)

Please note that the information in boxes indicates the way these guidelines were operationalize by the PHM Global Secretariat, hosted by Community Health Cell (CHC), Bangalore, on behalf of the India region from January 2003 to date

A. SECRETARIAT

- The Secretariat will be hosted by different regions in rotation
- Some of the activities will be retained at the previous secretariat
- 2-3 years will be the period for the secretariat to be in one region
- Use of a letterhead renamed as People's Health Movement reflecting steering group of networks will be promoted
- The secretariat will be supported by a steering group in the decision making process
- Secretarial support group will be evolved for communications and publications, media, PHM exchange, funding etc.,

B. CRITERIA FOR SELECTION OF HOST OF THE SECRETARIAT IN A REGION

- Willingness to host the secretariat by the organisation and endorsement by the regional circle
- The organization must have skills in communication, management, finances, project implementation and reporting
- Must be inclusive and have skills in networking and advocacy
- Must be committed to the PHM vision and the People's Charter for Health

PHM Global Secretariat, Bangalore, India (2003-05)

1. PHM India unanimously decided in Bhopal, India, in July 2002 that it would host the next phase of the Global Secretariat and requested CHC to do so on its behalf.
2. CHC was selected because it had nearly two decades of experience of promoting community health concerns, building and supporting networks and skills in advocacy, communication, management, fund raising and project implementation .
3. CHC had also been deeply involved in the whole PHA1 mobilization process in India and had been a resource person for PHA1 as well. In addition CHC had worked with many of the networks that came together to form PHM India before 2000.
4. CHC agreed to depute Dr. Ravi Narayan, its Community Health Advisor, (who had been a public health consultant and people's health activists for nearly 30 years) on a full time basis from January 2003 till March 2005. A full time office secretary, Srinidhi, was also deputed from CHC for the same period.
5. Dr. Ravi had worked with the PHM secretariat at GK, actively since November 2001 and Dr. Qasem overlapped as co-coordinator with Ravi from January to March 2003.

PHM Global Secret

C. FUNCTIONS OF THE SECRETARIAT

- Facilitation and empowerment of PHM vision
- External / Internal communication in PHM between member and circles
- Management of collective initiatives and events
- To design and execute planning, monitoring and evaluation of PHM activities
- Fund raising and financial management
- Working with members, donors, facilitators, contact points etc.,

PHM Global Secretariat, Bangalore, India(2003-05)

In addition to the above mentioned functions, the Bangalore Secretariat undertook two more additional tasks:

i. Dr. Ravi along with Dr. Zafrullah was the convenor of the WHO Advocacy Circle, which in addition to regular advocacy initiatives with WHO, also organized PHM presence and related events at WHA in Geneva, in May

2002, May 2003, May 2004 and May 2005 respectively.

ii. From November 2003 till March 2005, Prasanna – the Communication Officer also acted as the website manager. From April 2005 the website was supported by a PHA 2 related project with additional team members on a short term basis till September 2005.

D. MINIMUM NEEDS FOR SMOOTH FUNCTIONING OF THE SECRETARIAT

- Full time Secretariat coordinator (on deputation to PHM secretariat from hosting organisation)
- A communication officer capable of dealing with communication challenges including website
- A technical officer to help the coordinator (could be short term volunteers or short term linkage from the host organization or region)
- A person for accounts (part time or flexi time)
- Some office infrastructure - computer, telephone, fax, basic library and office space drawn from hosting organization and supported by PHM budget

PHM Global Secretariat, Bangalore, India (2003-05)

i. In addition to full time coordinator and full time office secretary, a full time communication officer, Prasanna S.S. was also appointed to support the communication needs of the Secretariat.

ii. While it had been proposed that the PHM secretariat should have a technical officer to support the coordinator, CHC did not appoint a separate technical officer since there were many staff members and fellows in CHC, who supported the PHM Secretariat in this function.

iii. To maintain distinct identity of the PHM global secretariat from the host organization (CHC), a separate office was rented with a separate phone number and email identity.

iv. In order to reduce the burden on PHM budget, CHC advanced the rental deposit for the new office and provided most of the furniture, telephone, computers and other equipments.

v. A separate letterhead was prepared as Template and used as required. Apart from the local addresses and contact details, it also had the list of regions and founding networks to highlights the global diversity and solidarity of CHC.

vi. A small India region secretariat support group consisting of B. Ekbal – PHM India Convenor, Mira Shiva – PHM Steering

Group member, Amit Sen Gupta – PHM India Joint Convenor and Mohan Rao – PHM India resource person was established and all communications and decisions were marked to this four member group to maintain a close link of the secretariat with the region, elicit various forms of support and ensure accountability and transparency. Later this was expanded to other joint convenors of PHM India joint convenors as well.

E. SECRETARIAL SUPPORT GROUP

1. Steering committee

- A steering committee consisting of representatives of the 8 founding networks and the focal points of 13 regions of PHM along with the incoming and outgoing coordinators will help in collective decision making.

- It will meet at least once a year to take stalk of the evolution and challenges of the movement and plan responses and strategies

- It will also constantly identify regional / international events that could be used as strategic opportunities for PHM participation, promotion of PHM concerns and initiatives and smaller group steering committee meetings and dialogue.

- A steering committee discussion group (yahoo group) will be established to help the secretariat keep all members involved and informed in all the key decisions.

PHM Global Secretariat, Bangalore, India (2003-05)

i. The steering group during this period consisted of representatives of IPHC, ACHAN, WGNRR, HAIAP, TWN, GK, DHF and CIROAP – the eight founding networks. Since April 2004 there has been no CI representative.

ii. The steering group also consists of representatives of 11 of the 13 regions (South Asia, South East Asia, India, Southern Africa, East and Central Africa, Middle East, Europe, North America, Central America & Caribbean, South America, Australia & Pacific). China and West Africa had no representative.

iii. Steering group meetings took place in January 2004 in Mumbai – India and April 2005 in Bangalore-India and informal steering group meetings during the WHAs in Geneva in May each year. A special group meeting was

organized on 23rd July 2005 at Cuenca, post PHA2.

iv. Steering of PHM through steering group email and annual meetings was not as successful or effective as the secretariat team expected due to inadequate responses by steering group members to email communications from secretariat and others; lack of clarity of roles and responsibilities and other constraints. Since April 2005, new organizational options to enhance governance structures and strengthen decision making processes are being explored. The division into 13 regions also doesn't seem practical or viable and during the proposed organizational restructuring, reducing the number of regions is being considered while at the same time increasing regional coordination responsibilities. This was further discussed at the Cuenca meeting.

2. Funding group

- A 6 member funding group will assist the Coordinator in financial and fund raising matters helping to evolve the project proposals, budget, logical frame and identifying and dialoguing with potential partners on behalf of PHM.

PHM Global Secretariat, Bangalore, India (2003-05)

i. A 6 member funding group consisting of Andy Rutherford (One World Action, UK); Olle Nordberg (DHF, Sweden); Maria Zunega (IPHC, Nicaragua); K. Bala (HAIAP, Sri Lanka); Qasem Chowdhury (GK, Bangladesh) and Prem John (ACHAN) supported the coordinator in fund raising strategies and related financial management through e-group discussion and occasional meetings related to PHM events.

ii. One World Action – UK, continued to support the PHM secretariat by hosting the PHM – OWA account in UK which processed and received all the grants and donations facilitated

by the funding group. Andy Rutherford facilitated all these activities in an honorary capacity and without any contribution to OWA for providing his and related services.

iii. During the 2003-05 phase, the fund raising shifted from large government or international funding agency grants (that had supported PHA1 and the early PHM phase) to small focused grants and donations for specific events, needs and initiatives of PHM. This was called the "Friends and Neighbour Policy" and regions and founding networks that also encourage to raise funds of their own to support PHM activities as expressions of their solidarity. This was a highly risky approach requiring lot of communication and perseverance but on the whole help to revive greater solidarity in the movement.

iv. For PHA2, since this was a large international event, Maria Zunega was invited to be the convenor of the international organizing committee and also support additional fund raising activity. Some new additional members were invited to join the PHA 2 fund raising process and these included Sarah & Lanny (USA); Maija (Canada); WGNRR and SAMA (India); Sunil Deepak (AIFO); Manoj (WCC); Margaret Posada (Latin America); Thelma Narayan (India); Andrew Chetley (UK); Unni and others.

3. Communications and media circle

- A group of PHM members will volunteer to be part of the communications and media circle and will facilitate both internal and external communication and thereby contributing to the expansion of the decentralized movement.

- They will share responsibilities for

  - Website and related communication activities and through this increase the visibility of the movement
  - Facilitating and exchange of ideas and dialogues through E-mail communication, eg., PHA Exchange
  - Issue of timely press releases and publication of the same
  - Devising methods to overcome the digital divide, eg., in requesting regional contacts to download, photocopy and post mail to members in the region.
  - Launch of campaigns (for eg. Million signature campaign for Health for All)
  - Regular press releases on health issues of global concern

PHM Global Secretariat, Bangalore, India (2003-05)

i. Andrew and Prasanna's efforts to organize a communication strategy and circle as an integrated activity of PHM did not succeed during this phase. However, all the above component communication functions were carried out with committed volunteers.

ii. Newsbrief : Prem and Qasem brought out regular news briefs from No.8 to No.15 nearly every 3 months. These were printed at GK except No.15 (in Bangalore).

iii. The PHA Exchange – a sort of e-group communication and discussion group was moderated by Claudio Shuftan, Vietnam,

very effectively throughout the phase.

iv. PHM Media releases : Unni and Satya regularly facilitated media releases throughout the phase and especially around WHAs, IHF and other events.

v. PHM Website : Nand (Costa Rica) managed the web site till November 2003 and then handed over to Prasanna. From April 2005, the website was managed as a special pre PHA2 project supported by a Health Link –UK facilitated DFID grant which enabled the secretariat to have a full time web editor since the effort to run the website by an overworked secretariat was not very effective. It is now suggested that in the next phase, there is need to decentralize the web management to any region or organization volunteering to take up the responsibility without it necessarily having to be the responsibility of the next secretariat.

vi. PHM Charters : The translations of the Charter into different languages and their promotion was facilitated by Pam Zinkin (UK) as a volunteer.

4. Publications / PHM resource centre

- The GK Savar centre, Bangladesh, which hosted the PHA 1 and the secretariat for the first two years will continue as a PHM resource centre
- It will bring out a regular News brief and related publications to highlight the activities of PHM during a specified period
- It will publish the policy/ background papers / charters in

coordination with the Secretariat and organizations / individuals from the regions.

- A small editorial group would support this activity.
- Sometimes a small additional group would be formed for a specific publication
- The PHM resource centre will also keep track of all the publications, handouts, educational and promotional materials that evolved in the PHM –Globally, regionally and at country level.

PHM Global Secretariat, Bangalore, India (2003-05)

i. The GK publication unit – Gonomudran – continued to print and publish the news briefs; the People Charter for Health; the PHM HIV / AIDS charter; the Mumbai Declaration and reprints of the PHA1 background documents and Voices of the People and other publications.

ii. On some occasions, as in the case of Alma Ata Anniversary publication, HIV/AIDS Charter, News brief 15 etc., other options were also explored. Many regions printed their own publications as well.

F. SOME OBSERVATIONS FROM EXTERNAL EVALUATION REPORT (JUNE 2004)

As we evolve processes of transition to new regions and coordinators, it may be useful to keep the following observations from the evaluation report in mind – so that these trends may be sustained and strengthened further:

- "There is now increasing dialogue and communication among key movement focal points. Externally, there is a great visibility of the PHM in some arenas and for a".
- "There is now more clarity and transparency on how activities are funded, how funds are being shared and made to work more effectively is combination and with complementarity".
- "The concept of PHM participants bringing their own contributions to the table to enable things to happen, rather than looking to PHM (particularly the secretariat) as a source of resources is beginning to be internalized. This focus on contributions is one of the key indicators in determining the strength of a network or a movement".

- "There has been some enhanced cooperation. Links that are evolving with the World Social Forum, the strengthened connections with WHO and PAHO, the development of working relationships with the Global Equity Gauge and Medact around a global health watch process are simply a few of the most visible positive trends.
- "Enabling dialogue and discussion in a number of forums is increasing, but there is scope for more. The Secretariat is demonstrating leadership in this, as are some national groups. The Alma-Ata related meetings throughout 2003 are good examples.
- "Communication strategies and practices – both internal and external – are improving. Again the Secretariat is demonstrating leadership, and the response of many participants in the movement to share information is becoming more evident".
- "Enhanced cooperation is important so that PHM is visibly seen as a pro-active, inclusive and welcoming movement and is a platform that enables people to participate, without them having to convert to a particular belief, ideology or approach".

PHM Global Secretariat,
Bangalore

10th August 2005

Funding Meeting Report (2004)

From: PHM_Steering_Group_02-03@yahoogroups.com on behalf of María Hamlin Zúniga [maria@iphcglobal.org]
Sent: Tuesday, 4 October 2005 12:18 AM
To: PHM_Steering_Group_02-03
Subject: [PHM_Steering_Group_02-03] Report on funding reflection December 2004
Friends, I think it imperative to revisit this report from December 2004
Maria

Funding reflection meeting
Held at One World Action ,London UK
Thursday, December 09, 2004

Present: Andy Rutherford, One World Action
Andrew Chetley, The Exchange, Healthlinks
Jorge Sanchez-Chiaro, Healthlinks and The Exchange * partial attendance.
Pam Zinkin, UK, IPHC and PHM
Patricia Morten, Global Health Watch * partial attendance
Unni – arrived in the late afternoon.
Maria Hamlin Zuniga, IPHC, IOC –PHA2

The first part of the meeting was spent in discussions about the present situation.
There are very few persons with strong fund raising experience involved in the past and present PHM fund raising groups or in the PHM generally. Most persons have been receivers of funds and have not generated funds. There are exceptions, but in general this is the situation.

PHA1 had support of DFID, the Dutch government, Ford, Rockefeller, SIDA through DHF, Finida through ISF and OWA and Belgian Government through WSF. There were some NGO funders mainly based in Bangladesh and through GK. PHA 1 and PHM have been heavily dependent upon OWA, DHF, and European donors. Ravi's policy of Friends and Neighbors has been successful for small grants since PHA and has been able to keep the PHM secretariat going and enable significant PHM presence at a series of international events.

PHM has visibility and an important advocacy position with WHO, but this does not assure general direct funding for the PHM.

At present PHA2 and PHM do NOT have core funding. The Dutch refusal to the grant application was symptomatic of the institutional trends at this time. There is potential for funding sources in some bilaterals and NGOs but this is also becoming very difficult.

There is a need to decentralize, to breakdown the PHM into a series of projects and into regions and sub regions and to look for funding for specific activities. For the PHA2 this can involve such as workshops, publications, communications, as well as enabling representation from the different regions at Cuenca. The PHM and PHA2 categories need of course to be complementary and coherent.

We need to respond to the organizational pressures and the recommendations of the PHM evaluation. The structure and the funding are interrelated and there is a need to strengthen the parts of PHM and the types of work.

However, who does this? This requires time, efforts, clarity, understanding of the different activities and who is involved, etc. That is why the development of a plan of action is essential. This is expected to be an outcome of PHA2.

The regionalization issue:

- If PHM is to be strong and viable it needs other organizations around it and within it to also be strong and viable.
- There is a need for regional structures owned by the regions and countries with stakeholders who own the project.

- Potential for regionalization exists with differing experiences and capacities according to the region.
- Need for connecting activities across countries building local expressions of the movement. Build upon common issues and learn from one another.

Reality check: What are the core maintenance areas or core functions of the current secretariat that must be undertaken regardless of the structure of the PHM

- Representation
- Communications
- Charters and other publications
- WHO Circle
- Decision making: debate and discussion.
- Finances and reporting

These correspond to some of the areas agreed in our agreed plan for the structure of the PHM. There can be a link between say a Communications Circle and attempts to raise the funding for it. This can also be true for regions and countries. (This is effectively what is the basis of the planned application to DFID for PHM work in Asia.)

We need institutional buy in to these functions. Therefore it is necessary to identify core individuals, institutions, organizations that are willing to provide time, energy and salaries for persons to be involved in PHM.
What regional initiatives have a global reach?

We need to develop a framework set of proposals to open opportunities for funding and to sell the "chunks" that are marketable. Funding can then be secured for the key functions rather than the total of the PHM. This is done through coordinated fund raising, rather than competitive fund raising. This must be done in a way that responds to the current funding climate and the many changes in the structures and priorities of the donors.

It is increasingly clear that there simply will not be large chunks of global funding.

Identify those who want to engage and move forward as an outcome of PHA2.

Taking stock:

Basically there are no funds available to PHA2 and to PHM at this time (Nov. 23).
Actually there is a balance of 168. Pounds sterling in the OWA account.

There are effectively no funds in Bangalore, or Cuenca.

Patricia reported on the GHW which has funds until February and is presenting proposals for the advocacy phase and 2006 - 2007 of the GHW. Proposals are being presented to SIDA Sweden through Gega. Medact and GHW are approaching other funders and potential funders including IDRC, BMA, and IFHHR. Interest has been expressed by Greenpeace, Tear Fund, World Vision, and Water Aid.

We reviewed and made additions to the funding update information. Additional information was provided concerning the rejection of the PHM project by the Dutch government. A request is being made to DFID Asia section for PHM, but the outcome is uncertain.

PHA2 information was shared putting emphasis on the strengths of the work to date. Actually we are far ahead of the PHA1 process in terms of venues, plans, staff, volunteers, communications, logistics and the strong vision and commitment of the groups in Ecuador. We also have moved along considerably on the overall program plan. The foundations are in place for PHA2 to be a great success.

So now we need to find the additional funds, and emergency funds to tide over the secretariat until the funds from the northern NGO donors start coming in during January and February.

Andrew suggested working with the Communications Initiative and with the Reuters Foundation for funding young journalists to participate in the PHA2 and then make links for follow up on stories in different areas of the world.

Unni reported on the initiatives that will receive support from Action Aid in Asia and Africa. He will provide further information about this in a short report.

Conclusions:

We agreed to continue to work on strategies for the sustainability of PHM, and looking carefully at regionalization. We need to develop a proposal and circulate it for discussion and decision making at the PHA2.

Future funding will depend on our capacity to repackage our thinking related to fund raising looking for support for thematic as well as regional support throughout the world.

We strongly urge persons on the funding group and all the members of the PHM Steering Group to actively search out funding opportunities, even the

smallest grants from southern based organizations.

Mehz 7/12/04

Minutes of the PHM Steering Group meeting held on 11th and 12th April 2005 in Bangalore, India (2005).

List of people who attended the meeting:

1. Ravi Narayan, PHM Global Secretariat
2. Qasem Chowdhury, Bangladesh
3. Zafrullah Chowdhury, Bangladesh
4. Ekbal, India
5. Abhay Shukla, India (only on 11th April 2005)
6. Mira Shiva, India
7. Prem Chandran John, India
8. Unnikrishnan, PHM Media
9. David Legge, Australia
10. Edelina De La Paz, Philippines
11. Evelyne Hong, Malaysia
12. Sarah Shannon, USA
13. Lanny Smith, USA
14. Maria Hamlin Zuniga, Nicaragua
15. Patricia Morton, London
16. Hani Serag, Egypt
17. Andy Rutherford, London
18. Bridget Lloyd, South Africa
19. Mwajuma Masaiganah, Tanzania
20. Lalit Narayan, India
21. Abraham Thomas, India
22. Nisha Susan, India
23. Prasanna Saligram, India
24. Sarojini, Sama, India (Only on 11th)
25. Deepa, Sama, India (Only on 11th)

11th April 2005

PHM Regional reports:

Chair: Qasem Chowdhury

1. PHM Regional reports of the happenings in the various regions since the Mumbai Steering Group meeting were solicited and Qasem outlined the structuring of the regional reports on the following lines:

    a) Organisational Issues
    b) Events in the regions
    c) Communication and Publication
    d) PHA2 mobilisation

Australia, David Legge

a) He outlined that the region was not doing well on the regional level as it is still confined to the Australian country as such with no much forward movement on the New Zealand and other countries of the region
b) But the Region was greatly helped by 6 visitors from PHM International. This facilitated a galvanization of the region
c) Subsequently in PHM Australia has a strong presence of Students
d) PHM Australia is undertaking a project on the issue of "Brain Drain" from the perspective of a receiver nation
e) PHM Australia has a neat website and a strong email list server
f) They are planning to bring a strong contingent of indigenous people for PHA-2
g) PHM Australia is very pleased to announce that Fran Baum has been nominated as one of the Commissioners of the Social Determinants commission
h) Ravi added that Mary Murray who was very active during the PHA1 has come back into action and written to the secretariat and wants to slowly get back into action and mobilize in New Zealand

Southern Africa, Bridget Lloyd

a) Southern African region joined EQUINET meeting in Zambia
b) Last year some of the regional people attended the Johannesburg meeting of GCAP
c) 4 distinct sub-groups have emerged working on various issues

- HIV/ AIDS circle – working around easy access to ARVs on which groups like Treatment Action Campaign are working
- Community Health Worker lobbying
- Public Sector prices group working against the Brain Drain and issues like National Health Insurance
- Find a forum for Public Debates in which people are invited for debates than an open forum. They have started issuing newsletters titled " Critical health Perspectives". Four Issues have come out till now on various issues

d) There is an increasing recognition of the efforts of PHM South Africa
e) There has been a flurry of debates happening and hence lots of emails.
f) South Africa would like to have a website for themselves which would ease some communication aspects but at present are not in a position to have one
g) There is a problem of paucity of resources
h) Recent Meeting in Zambia was very promising and a follow up meeting was planned for 18th April

East and Central Africa, Mwajuma:

a) Built Linkages with various societies immediately after WSF, Mumbai and decided to launch Tanzania Social Forum. Launched on last Jan 15th
b) PHM was invited to be among keynote speakers at the launch
c) Human Rights was addressed by Tago – Nefco Group
d) Made a film on "Roll Back Malaria"
e) Minister of Health (?)
f) We managed to telecast the film in TV bringing in the PHM stance on the issue
g) June 2004 we had the conference " Challenging Injustice". This publication was translated to Swahili
h) Established links with other organizations of East and South Africa during the Zambia Meeting
i) A summary report of the meeting would be circulated
j) From Kenya Malachi could not come due to lack of funds
k) HEPS, Uganda was represented and they are back into action
l) At the Durban meeting we got more French Speaking countries of Africa
m) Ravi informed that there is a need for greater mobilization in Africa and that this mobilization has to happen in a bottoms-up manner
n) Ravi mentioned that the Zambian meeting was a very promising one in that direction and the meeting came up with 3 main suggestions
    - All the networks felt that it was a great opportunity
    - Each of these networks are invited to attend PHA2
    - One of the plenaries to be Africa oriented especially on the pandemics
    - From this mobilization the future structure of the African Region to emerge
o) Maria at this point intervened and mentioned that Sunil Deepak has assured participation from the Portuguese speaking Africa and WGNRR is mobilizing the West African contacts for PHA2

South East Asia, Delen

a) An invitation was extended to participate in the conference on "Health Perspectives…..(?)
b) At a meeting in Jakarta, 2 groups, The catholic Health Group and the Muhammadiya Group could be brought together on a same platform
c) An introduction on Charter and Mumbai Declaration was given
d) But there exists a problem of communication
e) In July, strong presence of PHM in the HIV/AIDS meeting in Bangkok
f) PHM HIV/AIDS charter was brought out
g) Some of them got a chance to meet the WHO director as well
h) Unni and Action Aid were very supportive during the whole conference
i) There is a meeting on "Access to Medicines" in Penang, Malaysia organized by HAI-AP
j) In Philippines a community based health program was launched (?)
k) The website of HAIN is linked to PHM and PHA2 websites
l) PHM Philippines is lobbying for various health rights and for increasing the health budgets
m) There have been some political problems – some of the community leaders are getting killed
n) Some contacts with Cambodia are made who are Action Aid contacts
o) There is a question of funding from the other regions
p) Lanny was in Philippines addressing a group of students from the Asian Health Institute (?)

TWN, Malaysia, Evelyne

a) Difficult to organize PHM Malaysia
b) There is a privatization campaign under which 40 groups are involved to oppose the privatization. PHM has been invited to be in the steering committee
c) Mention was made to make a start of PHM Malaysia but there are problems involved as political parties are involved
d) Launch of the Global Health Watch report may be used as one more entry point
e) Plans to use the privatization campaign to promote PHM
f) The group dynamics are pretty tricky and money is the problem
g) There is an attempt going on to get TWN to arrange for a meeting
h) Publications: AIDS books were released during the Bangkok meeting
i) Using the publications, briefing papers to publicise PHM
j) Andy intervened and told about the Asia Europe People's Forum held in London in which there were a lot of people from South East Asia who were working on the issue of water and privatization. He said that he would link up the people from Malaysia and Philippines with Evelyne and Delen
k) Ekbal mentioned about the launch of APPACHA in Bangkok

Cambodia

- 2 meetings were held in Cambodia based on the people who had come to PHA1
- Both meetings focused on HIV / AIDS. Need to see how this could be used as a platform for PHM

South Korea

Ravi mentioned about Clara Kim who has been active in Korea and are struggling on access to medicines after Patents Amendment by that country

Thailand

a) Ravi mentioned that after Mumbai Meeting Chiranuch and Lawan of MSF who had come to IHF, Mumbai had become active in Thailand
b) There has been a new opportunity in Thailand. Janet Wong has been active in this has acted as a catalyst on this issue. UNESCAP wanted to set up a new "Vision Mission" for health systems improvement in about 50 countries of ASEAN. WHO & PHM were put in the same status. PHM has got deeply involved in this and a 5 day session with the people was arranged.
c) Thelma, Chee Khoon, Sundar were there to operationalise from a Vision Document.
d) There was a meeting with the Ministers arranged. The countries include from Pakistan to New Guniea. Sundar from India attended the Ministerial conference.

e) Unfortunately Janet has since left UNESCAP. When Tsunami happened, Japanese government wanted to support some efforts. Janet has forwarded that to PHM. This proposal has been sent to some of the PHM people in the SE Asia

f) Dr. Suwit of the Health Ministry is keen to send a delegation to PHA2. They have a National Health Assembly every year

g) Unni intervened and talked about 3 constituencies who could be PHM partners.

   a. An increasing movement in Thailand against the FTA. The Labour campaigns are fighting against FTA.
   b. The campaign for cheaper ARVs in Bangkok
   c. Thai Electricity union (essential services) has shown interest in PHM

Claudio has been doing something in Vietnam on the mobilization front

China has been very difficult. Still no entry. China has been captivated by GONGOs

South Asia

India:

1. Organisational Structure of PHM India fairly well knit
2. PHM India has also drawn a national People's Charter of Health and is called Jan Swasthya Abhiyan and is a coalition of 21 national level networks
3. There is a national secretariat hosted by CEHAT with Sarojini and Vandana helping the secretariat out from Delhi
4. JSA has a presence in 21 Indian States and has state level coordinators. The national coordination committee meets at least once in 6 months and there is a meeting slated for 18th April
5. There are some agenda at the National level but each state does evolve its agenda by itself

Events:

1. Right to Health Care
    a) Right to Health Care campaign launched on the Alma Ata Anniversary. This constituted a series of People's Health Tribunals at the state, regional and finally culminating in a National level Tribunal. Documentation of denials of Health Care. More than 200 cases of denials from all the spheres of health care
    b) National Human Rights Commission (NHRC) for the first time recognizes Health as a Human Right
    c) All States apex health officials were forced to come and made to respond
    d) National Action plan drafted and NHRC made some fine tuning and released it as its document

2. Dialogue with the National political parties was held on March 12, 2004 before the National elections
3. A campaign against 2 child norm was held. There were 220 participants out of which 160 were the affected people
4. Campaign against the Indian Patents Amendment
5. Mira talked about the Supreme Court Case on the Drug Price Control Order
6. She also talked about the presentation by PHM India to the Sandhu committee looking into the spurious drugs
7. There is a new program launched by the Government of India on Rural Health called as 'National Rural Health Mission" in which 23 members from PHM India were represented during the drafting of the program
8. All this in PHM India happening with absolutely no funds

Publications:

Make Health Care a Fundamental Right
Handbook on documenting the Denials of Cases

Brochure of PHM India
Policy Brief talking about the status of Indian Health Care

Sri Lanka

Ravi updated the group about the activities in Sri Lanka

- They have a good group called Sarvodaya which has been involved in the peace processes
- PHM Sri Lanka meets every month and discuss issues
- Minister of Science and Technology is a PHM contact

Nepal

- Political Crisis
- PHM Directly involved through Mathura Shreshta
- Mathura keeps sending mails

Pakistan

- Ravi and Ekbal invited by Pakistan PHM after the IHF meeting in Mumbai
- PHM Pakistan which was dormant after PHA1 was reactivated
- Ekbal and Ravi had meetings in many parts of Pakistan
- PHM charter translations in Siindhi, Punjabi and Urdu
- 5 state level PHM groups are formed
- National Health Forum and South Asia Health Forum has been planned.
- Dr. Talib is a full time PHM coordinator
- In June they are planning a national meeting to decide on PHA2

Bangladesh, Zafrullah

- PHM Bangladesh has a new committee from April 2004, new direction, with Shafiuddin a grassroots agricultural movement bringing in a new dimension. The new director is Imam Uddin, a trade unionist
- Mumbai was an inspiration to some of the women who had not left their villages
- One of the major campaigns was "No to GM foods" while bigger NGO's were silently supporting GM foods
- PHM Bangladesh has been very active in the relief efforts in the floods

- Monga Region of Bangladesh for about 6-10 weeks in a year no food would be available resulting in migration
- Massive demonstration to prevent "immunity" to the criminal crimes. PHM Bangladesh did a lot of work
- PHM Bangladesh negotiating with all the medical colleges to include the Charter in the curriculum
- Anti Tobacco Bill has been passed. It is also been made effectie from a particular date – 30th March 2005. No smoking in public places. There is a fine also for violation
- There was also a mention of many of the Bangladeshis who failed to make it to WSF – 2005

Middle East, Hani

- There has been lot of changes politically and the situation is very tricky. There has been a delay to implement this change
- There is an increasing tendency of Privatisation in Egypt in Health and Education using different titles. Most of the activities are geared up for this
- Organisationally there has been more effective communication between different countries Egypt, Lebanon & Palestine. Efforts to include other countries.
- Neither Middle East or the Arab region is homogenous. Gulf countries are very different, so are the former Soviet republics hence there is a need for more discussion
- There has been an increasing coordination with "Arab Network for Development". Most of the PHM people are very useful members of this network and the Cairo Meeting is being supported by them
- Lots of seminars / conferences were held in Amman, Jordan
- Websites of different organizations of the PHM region changed to look like PHM website
- Events: 3 campaigns.
    a. Health Insurance Campaign (targeting health sector reforms with a strategic starting point of Insurance)
    b. Accessibility of Medicines – There have been structural and conceptual changes in the Pharma sector. American Pharma companies demanding TRIPS+
    c. Right to Health – A campaign to change the by-laws to speak more about patients' rights
- Lots of publications brought out but mostly in Arab and some are also uploaded onto the website
- Lebanon Meeting: Lanny Smith talked about this. It was nicely done by Ghassan Issa and the meeting was well attended. David Sanders presented both comprehensive Primary Health Care and Charter & lot of people came to meet them after the meeting. Lanny presented PHA2. The next day's meeting was attended only by women They were concerned that they were not invited and later on had a lot of questions on PHM

ran, Lanny, Ravi

PHM Iran has been doing very well. Lanny has been there. Dr. Barzgar is in touch with the Secretariat. They have a women's circle and a rehabilitation circle. Nursing groups involved during Bam earthquake. They are going beyond charter. Poverty book has been translated.

Kazagystan

Prof. Maksut was there at the PHM session. He has been organising civil society on health issues and their first task has been the translation of the charter and the charter has arrived

Global Campaign against Poverty (GCAP)

There was a brief discussion on GCAP with some of the members expressing reservations about the whole process like very centralized, lots of celebrities associated with it even Tony Blair

Europe, Patricia Morton

- It has been difficult to mobilize in Europe with 26 countries and most of them outstretched. Most of them individuals who are working for international causes and not for Europe!
- Need to develop linkages with other movements / organizations in Europe
- An intern is going to join PHM Europe for working on the mobilization for PHA2
- One of the main mobilizing events was the European Social Forum (ESF). "European network for Right to Health" formed within ESF. A call for action was given to Defend the Right to Health
- Recommendation is that they are stronger than PHM in Europe with trade union organizations etc., associated with them. So there is a need for PHM Europe to join them A suggestion that they be invited and include them as many as possible for PHA2. They are mostly Spanish.
- Some of the groups were
    a. The Hungarian Anti privatization campaign
    b. Politics of Health Group – comprising of Academics and Activists. "UK Health Watch" report brought out by them
- Some of the events for mobilization to PHA2
    a. International Association (?)
    b. Mediterranean Social Forum, Barcelona

- Spoken to some of the Italians about PHA2 at Milan Meeting. A meeting scheduled at Bologna in May to discuss this further
- Requested for 75 participants than the suggested list of 50 for Europe

Andy

- Most of the political debate is around the constitutional revision of EU
- In France, core of the debate is on public services, France wants to avoid GATS. We could use it as a stepping stone for the campaign against "Privatisation of Health Services"

Lanny

MDM is very keen on PHM process. VP of MDM interested in PHM. The President of MDM to go to Cuenca. A chance for significant funding.

Scandinavia, Ravi

There is a group which has shown interest in PHM Sweden

IFMSA, 90 circles. They have offered support to PHM.

North America, USA, Sarah Shannon

- Organisationally 3 different strategies
  a. Local / Regional PHM circles. About 12 circles formed which are active to varying degrees and diverse in the areas of activity
  b. Campaigns – Save UNICEF campaign, Health & Trade, US Health Care reform, US Health Care system on trial at Boston Social Forum, Environment health & justice
  c. Opening spaces in some of the Public Health Organisations like Global Health Council, Public Health Association etc., who have been pretty conservative till now
- There were 15 or more events in Boston Social Forum
- There is a plan to build a People's Platform of Public Health after PHA2
- International Support has been provided by Lanny
- There has been limited success in establishing contacts with Canada. In October 2004 during CSIH, Canada, PHM was invited and Lanny attended the same. He had a very fruitful discussion with Maija. Had a good PHM caucus at the event as well. But after that Canada totally not in touch

North America, Canada, Maria

- People regrouping themselves in Canada and hence need some time. Canada is an enormous country and very dispersed
- Key people located in Vancouver area (Grass roots women's network)
- Health Everywhere circle formed
- Indigenous people from Canada would be there at PHA2
- There have been some movement in the French Speaking Canadian region as well

Latin America, Maria

- FTA's and TRIPS are the main issue in the region.
- The region needs solidarity from the US
- There have been some movements to create trade blocks to USA like Venezuela and Brazil
- There is a PHA organizing committee formed in Cuba

IHF / WSF , Lanny

- IHF – IV, more than 500 people, well organized. It was an ALAMES show all the way
- Throughout the meeting there was mentioning of PHM
- PHA2 got enough publicity
- A small lunch meeting among PHM people
- Contacted Brazilian Medical students translation group

PHA 2 discussion

At the outset all the participants in the meeting appreciated the tremendous efforts put in by the Latin American team to make PHA2 happen. Maria also conveyed the concerns of the lack of proactive positive support from the Steering group to the Organising committee of PHA2.

A brainstorming session was held to find out the concerns of the group present about the whole process of PHA2 and the issues that came out were the following:

Issues around PHA 2 raised for discussion

- Quotas
- Languages
- Selection process
- Visa
- Getting there
- Finding airfare
- Communication breakdown
- Structure of plenaries
- GHW
- Clarification pf purpose of assembly
- Focus on post PHA-2 activities
- Message to the rest of the world
- Messages to steering committee
- Accomodation
- Vegatarian
- Testimonies
- Concrete next steps
- Future of bilingual PHM
- Invitation of media
- Inclusion of people who have never heard of PHM
- Resource people
- Strengthen weaker regions
- Two websites
- Access for people with disabilities
- Mechanism for saying no
- Parallel events

Clarifications/Suggestions

- The version of the programme on the net right now is the March 7 version. A new one will be available soon.
- Papers must reach Cuenca ahead of the panelists
- Secretaries of plenary sessions organize the nitty-gritty of the sessions and therefore are all Ecuadorians. Presidents will be international representatives
- In every activity at PHA-2 there will be action points for PHM
- Testimony is not equal to speech. It can even take the form of a film.
- The maximum time for a testimony is five minutes.
- There could be a colourful opening session that symbolizes the global diversity of the movement.
- There will be a declaration of indigenous peoples which will be released soon fro endorsement.
- A translator network will be on campus organized along the lines of the International Women and Health Conference, probably with coloured Tshirts to indicate the languages they speak.

- All plenaries will have simultaneous translation in four languages (English, Spanish, French, Portugese)
- There will be food demonstrations as well as a food fair in Cuenca.
- The child delegates have to be 16 and below
- The quotas currently allotted are approximations and not rigid. The quotas do not include the members of the steering committee and special invitees.
- It would be better to invite those individuals, NGOs and networks that have constituencies rather than people who have merely the money to buy airfare
- The dialectical process of invitation and selection must happen quickly so that Cuenca can make arrangements for travel and accommodation. Cuenca has to book spaces for 3000 people because July is high season in Ecuador.
- The pre-registration form is available on the net so that people can express an intention to attend. The pre-registration forms will be made available in an online database accessible to Cuenca and the various regions.
- Final registration forms will be sent to people only if regional representatives approve of the invite.
- The assembly can accommodate 1500 people. The largest auditorium will accommodate 1000 people.
- Observers can come but priority will be given to PHM
- Delegate badges to ensure that people do not crawl through the cracks
- Every region must attempt self-financing however there are some potential sources of funding for airfare if proposals with definite names and details
- Discounts are available on airline fares if over a dozen airtickets are booked together no matter the point of departure
- The airlines flying to Ecuador are KLM-Air France/ Lufthansa
- No registration money has to be handed over before reaching Cuenca
- Cuenca does not have the infrastructure for credit card transactions
- There is a list of countries who require visas to enter Ecuador. Others can walk in.
- For others if they get an official PHM letter signed by Maria or Ravi they can pick up a visa from any consulate in 15 minutes i.e. if Ecuador has not banned them or considering banning them
- First meeting as PHM. If people came to PHA1 as networks PHM grew in that country/region. If People came as individuals then PHM did not grow.

Some further Suggestions:

- It was decided to send a personal communication to Arturo from the members present with their personal appreciation of the work done by the Latin American group
- Prem raised the issue of how after PHA1 nothing was wrapped up and Qasem was left alone to do all the things and a concrete plan of action did not emerge at that time. He also suggested that PHM needs to be expanded to have more younger people
- Andy agreed to Prem's point that there was a massive low after PHA1 and hence there is a need for progressive planning and space must be provided for the steering group to meet

- Abhay suggested that the 4th day afternoon must be a planning session for global actions / regional actions. Day 4 evening should be the Steering Committee meeting
- Ravi added that a 9th track on the organizational issues was added into the program. At this point there was a suggestion to have all the Steering group members housed at the same place as far as possible. Also a suggestion to the Steering group members to plan to come at least 1 day earlier and leave 1 day later.
- Sarah suggested that each of the Steering group member should look into the program carefully and see whether the action points / campaigns that each one wants to see for the next 3 years is incorporated in the same

Unaswered questions:

- Deadlines for pre-registration, registration, etc
- When is time allotted to discuss the action points so that it is put together for the declaration on the fifth day? Will participants be able to do this through a session on Day 4?
- The names responsible for different regions
- What will happen in the short opening session apart from the Savar to Cuenca photo display?
- Who is the facilitator for some sessions? Eg. The WTO session

Cheerful Thoughts

- This is actually the first assembly of the movement
- Steering committee members are welcome to come to Cuenca and plunge in before the actual event
- Global representation is possible if everyone on the steering committee and those from different regions send in ideas for names, sessions, testimonies etc.
- Events can be organized simultaneously in the different regions which can be transmitted via satellite
- The Alternative Events are very exciting and more can be organized

Points of Action

- Getting the delegate selection process off the ground quickly
- Let Cuenca know quickly
- Book tickets quickly
- Organizing exciting materials such as photo exhibits, children's films, posters etc to be handed over to the IOC at their mid-May meeting in Geneva so that it can go to Cuenca ahead of time for translation.
- Inviting delegates from indigenous communities both adults and children.
- Endorsing the Indigenous people's declaration
- Asking indigenous peoples to endorse the Charter

- Put together proposals to get funding for airfare from organizations such as WHO-Afro and the Women Trade Unionists (ask Sarah)
- Organize more alternative events

Funding for PHA2

Chair: Andy

Andy conducted this session as a representative of the Funding commission of PHA2. He opened up the session with 2 basic questions to the people present there

a) What has each member present in the room contributed till now towards the resources of PHA2?
b) What has been contemplated or in the pipeline for raising resources to PHA2?

David, Australia

- Australian Region focusing on the indigenous representation. Applications have been sent to various NGOs to support such people.
- They are also contemplating to solicit donation of frequent flier miles for supporting people to reach Cuenca

Sarah, USA

- Planning to bring 20 low income participants.
- They are also contemplating to solicit donation of frequent flier miles for supporting people to reach Cuenca
- Approaching Ford Foundation for support
- Women Trade Unionists – AFLCIO has also been approached to support some participants

Lanny, USA

- Managed a small donation from Doctors for Global Health
- Contacted MDM friends and hopeful on that front
- Possibility of MSF funding PHM people need to contact MSF and solicit funding .

Evelyne, TWN

- Exploring the possibility of TWN sponsoring the event on Health and Environment
- Maria has the break up of TWN contribution (?).
- Trying to get TWN to sponsor Trade and Health session(s) by TWN

Patricia

- Session on Launching GHW to be sponsored by the Canadian Government

Hani Serag, Egypt

- Developed a regional proposal and approached some organizations like Ford Foundation
- Approached WHO – EMRO.
- Concretely secure some people to participate from Cairo. Can support only people from Egypt
- Exploring the possibility of supporting the cost of workshops. Approached them (?) for 2 workshops

Mwajuma, East and Central Africa

- During the Zambian meeting most of the networks thought of funding 2 people.
- HAI Africa from Kenya indicated that they will look for a possibility with partner organizations (like HEPS)

Bridget, Africa

- Treatment Action Campaign does not fund for travel
- African Social Forum might have a possibility of funding
- There was a proposal that any shortfalls by PHM (part funding) was possible

Delen, South East Asia

Trying to raise funds within Philippines

Abhay, India

- Concrete proposals already given. Ekbal mentioned that Action Aid Asian offices are ready to support some Asians in which 3 could be from India

Sarojini . SAMA, India

- The possibility of funding workshops on women's issues along with WGNRR
- SAMA is also exploring funding possibilities for women participants with some of the women's based funding agencies like the Global Fund for Women etc.,

Zafrullah, Bangladesh

- Plans are on to send 2 indegenous women, 1 journalist, 1 woman academic, 1 fold singer, 1 student, 2 young people, 4 other members of other organizations.
- They have approached Action Aid and Oxfam for supporting
- Planning to approach a local TV station to sponsor the journalist

Mira

These were only suggestions from Mira and nothing has been explored.

- Sasacava (?) can be approached because they work on Leprosy and with them the DNDi angle could be explored
- There is a meeting of HAI-AP end of April and there also linkages could be explored
- Approach Diverse Women in Diversity

Discussions on the Funding

1. Delen asked whether WHO was committed to supporting. To this Ravi replied telling that he has spoken to WHO at various places like GFHR etc., and there is a possibility. PAHO has been very supportive to the Latin American group. EMRO, AFRO, EURO are definitely interested but the respective PHM regions need to approach
2. Lanny mentioned that he has spoken to a number of student groups who want their delegates to go
3. **Andy mentioned that the idea of supporting of workshops needs to be explored. He also made a request to Secretariat and IOC of PHA2 to prepare an e-mail pack of materials which can help local people to quickly approach funding agencies. Regions need to approach WHO voluntarily. There is a need to map the opportunities like Action Aid, Christian Aid, etc., to avoid more than one group to approach the same funding agency**
4. There was a suggestion also to not think of one big chunk of say 20000$ for 10 people but to split the same and then approach different people for smaller grants
5. GCAP supporting a workshop could also be explored

There is a possibility of IPHU scholarships for young people attend them as well.

Summary of Finances, Andy:

Andy gave an overview of the funding situation for PHM as a whole and PHA2 in particular as well

- As of 11.04.2005 the Secretariat of PHM owed OWN 1300$
- Cuenca secretariat was 2000$ in debt
- London Account had 1200 GBP

The following commitments were in the pipeline

- 30,000 Euro (53000$) from Cordaid
- 800000 Euro (110,000$) from SIDA, Sweden through Dag Hammerskjold Foundation
- DFID grant for website (6000$?)
- Misereor 50000 Euro for PHA2 secretariat
- Dutch government deeply committed to PHM but nothing concrete as yet
- Canadian CIDA also provisionally ok with supporting PHM but nothing concrete as yet

Further funding possibilities

- Maria also mentioned about the designated funds from some organizations.
- Save the Children Foundation was ready to sponsor youth from Africa. **African regions should actively follow up on this**

UNICEF was also interested. **Again regions to actively follow up with their Regional UNICEF offices**

Cheerful Thoughts

What the above means is that the essential costs of the Event (PHA2 secretariat) are covered for the Cuenca Secretariat. But what it still does not cover are the deposits made by the Cuenca secretariat.

WHAT THIS MEANS IS THAT THERE IS NOT A CENTAL POT BUT MAYBE THERE COULD BE A COLLECTIVE POT OF RESOURCES

12.04.2005

PHM Organisational Structures:

Chair: David Legge

Ravi presented the outline of the structure as evolved at the Dhaka Meeting

- Not 90 countries but 75 countries and 17 states of India
- Steering group consisting of 8 networks and 13 regions
- Geographic circles and issue circles
- Networking and organizational building
- Advocacy at various levels
- Secretariat – hub of a wheel

Questions:

- Whether the structures have worked better for each of the regions / networks?
- What has it enabled?
- What has it disabled?
- What could work better?

Hani Serag, MENA

- Initially it was more individual representation than the organizational representation
- Decentralisation of functions (Like Newsbrief etc.,) has not worked well
- In MENA only last year did it evolve from individuals to Networks.
- The structure did not specifically inhibit the process of growth of PHM in the region
- Functional

Sarah, USA

- PHM US has tried to replicate the global structure at the regional level
- Regional Circles and local circles are formed with a steering group
- Pulling people into the International issues circle
- Lack of clarity about the Issue circle convenors

Lanny, USA

- Region concept not worked well. In a tight place. Website mentions about North American Region with US and Canada together. But establishing links with Canada has not helped. Tried to get some coordination going but not successful.
- David at this point raised the issue whether there is an anti-US factor for which Maria replied telling that the people in Canada are trying to get going and are in their initial stages and need some more time to evolve

Maria, Central and Latin America

- There had been organizations even before PHM who were working on Right to Health and now beginning to identify themselves with PHM
- So PHM needs to recognize the organic nature of some of these struggles.
- In Latin American region PHM is considered too English Language oriented and hence there is difficulty.
- A proposal from the region is to try for regionalisation of the various functions

Patricia, Europe

- Language has been a major issue in the region
- PHM Europe needs to find a way of working with all the existing networks. The situation is very fragile and one of the ways would be to adopt some of these networks into PHM. For eg. Politics of Health group. Invite them to PHA2 and then tell them what they do is part of PHM's activities

Andy, Europe

- Structure has worked. The very fact that Patricia coming to the meeting than Pam is an example
- We are able to link in and co-opt some of the other organizations
- Taking cue from Maria's idea of decentralization and regionalisation, he suggested that funding circle could be one such which could be decentralized

Delen, South East Asia

- PHM was generically existing already in Philippines
- Need to have more global networks
- The idea was also to revive and strengthen ACHAN

Ekbal, India

- Structure has worked. 21 networks, different ideologies
- Binding forces are secular approach and concern against imperialist globalisation
- When it comes to State level, there is some amount of exclusion, one or two organization takes lead
- PHM India has been fairly autonomous and to some extent de-linked from the PHM international

Unni

- Unni raised 3 questions about PHM
    - Is PHM an Alliance?
    - Is PHM a Network
    - Is it a solidarity movement?
- He mentioned that PHM was a mixture of all the three components and we need to think of how to strengthen all the three
- One more good thing about PHM has been that there has been no Power Politics within the movement
- So the thinking now should be towards making Campaigns
    - Strategic
    - Structural
    - Timely with
    - Understandable messages

Qasem

- Some of the regions are very strong. So the question now is whether to continue with the 13 regions?

Bridget, South Africa

- Structure has worked. South Africa has begun to grow a lot.
- But there is a problem of communication because of e-marginalisation and no funds for paying transportation
- PHM related campaigns are delivered to the local countries
- Trade Unions are active but again go up and down with the funding situation
- Some sort of a local structure built up. Streering group a mixture of individuals and organizations

Mwajuma, East and Central Africa

- Structure is good and important as well
- There is a growing need for regionalisation within our own context. Regionalisation of funding needs to happen
- There are country by country problems
- Zimbabwe not going ahead at all
- Uganda – personality clashes. There was tension between those who attended the Arusha conference. Secretariat facilitated HEPS but did not work out. But now there was a meeting on 3rd April 2005 and things are on the move again with an event in June before PHA2
- Tanzania – The process is very positive. There is a contact point identified but waiting for the democratic process
- Kenya – Superb and active launch. Accepted by the government as well as NGOs. But now suffering from lack of funds

- Cameroon – Elvire coordinating. No active linkage. Some more people identified. SO have to wait for democratic selection
- **Dilemma: Should we wait for democratic process or should we go ahead with the people who are active?**
- **There is a feeling in Africa that PHM is an NGO with lots of money. When they know that there isn't much money, they retract and watch from the sidelines**

Achievements:

a) Linkages have improved, for eg. the Meeting in Zambia
b) Recognition for PHM in government circles
c) Lot of youth have been enrolled
d) Tried translation of lot of documents to Swahili

Insights of the whole discussion

- Move from individual to organization – circles help to institutionalize
- Challenges of engaging new countries or regions – not by "bureaucratic" responsibilities but to draw on many linkages done / and a need to be strategic
- Engage existing networks and organizations (Recognise the power of History)
- Issues / Campaigns have a big role to play
- Attendance at PHA has also contributed
- Whistle-Stop tours / meetings have helped
- Taking advantage of events
- Scale of organizations linked to reseources (travel, email, translation)
- Language
    - Implications for Regionalisation
    - Implications for resources (translations)
    - Meetings culture (multilingual)
- Alliances, Networks and Solidarity
- Implications of Rich vs Poor
- Circles promote inclusiveness
- The following Ideal Types of regions identified
    - Strong regions built on a generation of activity
    - Green fields which are still getting their act together
    - Countries where no PHM has as yet started

Future Directions

- Building local self sufficiency (local, regional, national)
- Distribution of global functions
- Regionalisation – Fewer Regions and language based?
- Importance of reflecting on our own practice and growth (today)
- Capacitation / renewal

Caution (Ravi)

- "TURF WARS"

- The dielectic of Generic vs Brand
- Contact Point selection
- Diversity
- Support to participations
- Regionalisation of Secretariat functions and issue circles at Regional Level

Capacitation

- Prem had earlier circulated a note on the capacitation of the regions
- Steering Group members have not played their role in PHM to the fullest extent
- Regional Capacity needs to be built up
- Regions to build its capacity on Communications / Computer friendliness etc.,
- There are certain non-negotiable things that need to be stressed while building the regional capacity
- Funding should happen more at the Regional level. Capacity building towards that end

International People's Health University (IPHU)

- Since IPHU has something to do with regional capacitation, David presented the concept
- 1 week orientation before the start of PHA2 to a group of young people who are sent by the respective regions
- Some key areas identified like Political climate of Health, Gender, Health as a Human Right etc.,
- The link for the IPHU is www.iphcglobal.org/www.iphu.org/index.htm
- Maria clarified that IPHU is for PHM and regions need to utilize this to build their capacities
- Mentor relationship beyond the 1 week training
- A suggestion came up to have a manual on "How to start up?"
- Regional ok is necessary for any candidate
- There is also a proposal to provide future linkage to "International federation of Workers Association"

Regional classification of PHM

- Ravi pointed out that the whole world was arbitrarily divided into 13 PHM regions. But obviously this has not worked to optimum. So we need to reconsider the same. Since communication has been the most difficult part and also taking into consideration the mobilization that is needed for PHA2 a note on the reclassification of the regions to 6 were sent.
- There was a big discussion that followed this and there were differences also on the classification of the Regions. Hence it was decided that the whole issue would be re-looked into by Andy and David when they are drawing up the concept paper on the organizational structure

- **Each Region to do 3 things**
  - **Assessment of the Region**
  - **Aspirational statement for next 2 years**

- **What role do we want the Global Coordinator to do?**

It was decided that both Andy and David would work more closely and in detail on the organizational issues and circulate a paper shortly

Regional responsibilities for the sake of PHA2

For the sake of mobilization for PHA2 the following people have been identified for various regions to help Maria and the IOC team to send the pre-registration forms to the respective regions

South East Asia – Delen
Bangladesh, Nepal – Qasem
India. Pakistan – Ekbal
Sri Lanka – PHM Sri Lanka
U.S. – Sarah Shannon
Europe – Andy, Pam and Patricia
MENA – Hani, Jihad & Ghassan
Australia – Fran Baum

Shift of the PHM Secretariat

- Ravi indicated that he cannot continue beyond September 2005 and the regions have to start thinking seriously about this.
- He also informed that the others in the secretariat team were also evolving their own plans and hence it was imperative that the secretariat had to shift
- Even for Sept. he needs to go back to CHC for a formal endorsement, so he wanted regions to seriously think of hosting the secretariat.
- No region was as yet ready to take over the function of the Secretariat
- Since no region came up with a proposal, Ravi in principle agreed to carry on till Cuenca where the decision was made only on the condition that by the time of PHA2 some region must be ready to take it over. The hope was also that since the functions of the secretariat were to be redefined with some regionalisation and decentralization happening from the initiative Andy and David would take, some region might consider hosting the secretariat

Global Health Watch, Patricia Morton

- The good news was that the whole manuscript was submitted to the Publisher just before Patricia left for India.
- 25 authors out of nearly 150 are from PHM
- Not necessarily a position document of PHM and there might be some slight deviations from PHM position as PHM is teamed up with Medact and GEGA for this
- Could be a key document for advocacy and lobbying
- Patricia requested for release in the regions in their languages and to be used by the local PHM regions
- Planning to prepare a spin for the media with the manuscript sent 4 weeks in advance of the launch. Working with Unni on this

- Something like a pre-launch is planned for G-8 summit, WHA etc.,
- A 16 page Advocacy document to be brought out. This is going to be the key campaign document. This would be translated to Spanish, German and French
- After the launch could be used for advocacy with schools of Public Health
- Could be used for e-mail campaigns
- GHW- I ends with 2005 end. GHW-II would begin with a move of the GHW secretariat to a developing world.

GHW and PHA2

a. Circulation of the chapters to the Panelists
b. Would be brought to the frontpage of the PHA2/PHM website
c. Workshop to take up local / regional watch groups
d. Regional Mobilisation (?)

Discussions on GHW

- Prem brought to the notice of the group Claudio's reservations on the last chapter. The last chapter is being rewritten with David Sanders sitting with Dave McCoy and others in London
- Prem also asked whether there would be any popular versions that could be brought out by the time of PHA2 just like we had the 5 booklets for PHA1
- Maria mentioned that GHW would be talked about in each of the sessions
- Authors could come for panels and panel discussions
- Sarah wanted to know whether success stories have also been incorporated

Media, Website and Communications

Media, Unni

- Merging of the PHM and GHW ideas. GHW to be used widely for media purposes. Working with Patricia on making this happen
- Starting May 2nd week – I phase - A first Alert to Journalists will happen. As of now from the feelers sent there is a tremendous response from the journalists
- Stage II- May 15th and July 5th – capitalizing on 2 events – WHA and G-8 summit
- Stage III – A week before PHA2
  A week during PHA2
  A week after PHA2
- Stage IV – A month after PHA2
- Challenge of media friendly data in terms of statistics and facts needed to kindle the interests of the journalists. Hopefully GHW will solve that.
- Live Webcast is still a question mark but hopefully PHA2 secretariat will solve the issue
- Indymedia people have been activated
- IPS has an interest as well.
- Alternative radio / TV is also being explored
- We need more people to work with us. More people, more messages, more information

- Most important would be the latest happenings, data, new statistics etc.,
- Unni and Satya to be the Media Team. 12 Journalists expected
- Lancet and BMJ would be invited

Crowd Pulling things

- Ordinary people doing extra ordinary work
- Colourful people - indigenous community (ceremony on day 1)
- Celebrities
- Events (Children's festival)
- The idea of the Refugee Camp being constructed at Cuenca
- All the local / regional events to be given a PHA2 spin

➢

Campaigns:

Building the People's Health Movement: Proposal for Consultation and Planning on Future Structure and Strategy (2005)

At the Bangalore meeting of the PHM Steering Group in early April 05 the organisational structure of PHM was discussed. The main issue precipitating this discussion was the nearing of the end of the period agreed for the India to host the Global Secretariat. However, there was a strong feeling across the regions that the discussion should include consideration of a more radical reworking of the PHM structure.

This paper is based on the minutes of this discussion.

At the end of the discussion DL and AR were authorised to prepare a proposal for a consultation paper and process for circulation to members of the Steering Group for out of session consideration.

If the broad principles and directions are endorsed the Secretariat be asked to work with DL and AR to rework this paper into a more formal consultation paper to be considered by regions, countries, circles and networks prior to Cuenca, anticipating further decisions at the Steering Group meeting scheduled for immediately post Cuenca.

Contents

Scene setting
General discussion
Regional Reflections
Learning from the Regional Review
Institutionalisation
Decentralisation
Typology of countries
Strategies which help to build on existing networks
Different perspectives on PHM
Communications and communications technologies
IPHU

Planning for PHM's Organisational Development
Units, transformations and timelines
Functions
Planning and implementation
Consultation

Scene setting

Ravi presented a 'where are we now and how did we get here?' talk about the current structure of PHM and how we got there. His talk was based largely on decisions taken at the November 2002 Steering Group meeting. See Attached.

Note was also taken of an email from Prem and two from Bala.

In his email Prem emphasising the need to focus on regional capacitation, including bringing on younger activists and referred to the importance of using the IPHU as an opportunity for bringing on younger activists.

Bala supported Prem's suggestion that we move to regionalise the coordination function. He also raised for consideration the need to incorporate or register PHM and maintain that registration in the one location even though the coordination function would be moving. Bala also indicated that it would be very helpful for him to have access to uptodate email lists of regional and country contacts so that other NGOs like HAI could encourage direct local level contact through their own peripheral structures.

Genèral discussion

Ravi expressed some frustrations arising in the complex relationships between the Global Secretariat and Steering Group members and regional/national focal/contact points. It was clear that the practice of national / regional focal points did not always conform to the expectations of the secretariat (based on decisions taken by the Steering Group in November 2002).

Maria announced that she will not be a candidate for Global Coordinator. Further that the Latin American group had taken the view that (in view of a number of factors including language) they were keen to create a strong regional secretariat and were in favour therefore of reducing the investment in the Global Secretariat; perhaps down to a global coordinating committee of regional coordinators.

Ravi announced that he will not be available to serve as Global Coordinator for more than 3-6 months after Cuenca. He foresaw working with the new Global Coordinator for three months.

Regional Reflections

We then had a round-up-by-the-regions of their reflection on:

1. what we need from global coordination and what we could manage in our own region;
2. how well the regional – global division of labour has worked for them;
3. how they see the developmental process and time scale for bringing their region to a stronger state of self-sufficiency

Hani, speaking for Middle East and North Africa, indicated that this had been discussed and that they were keen to develop a stronger regional secretariat, based in the first instance in an existing participating activist NGO. The ME&NA group contemplated reducing the investment in the Global Secretariat to a Coordinating Committee.

need to move to regional secretariat

Hani commented on how the presence of PHM in Egypt had progressed from being primarily about a few individuals, to being a network to being an organisation.

experience of growth of PHM from individuals to organisations and networks

Sarah and Lanny spoke about the experience of the US Circle. The decision to base PHM US on two existing activist organisations had been a good one. PHM US was making good progress in developing state by state and city by city PHM circles.

experience of growth of PHM US: setting up PHMs in cities progressively

value of 2003 tour of PHM leaders

However, the PHM US felt somewhat frustrated in discharging their perceived responsibility to facilitate the development of a PHM Canada. They felt that there could be barriers in the context of the US Canada relationship and that many PHM people had contacts with Canadians which also need to be deployed in bringing the Canadians into the movement. This discussion raised the need for a more strategic planning in relation to countries and regions which are not strongly networked or where PHM is not strong.

more international planning in developing PHM in countries where PHM is not strong

possibilities of people in other countries helping with contacts

Sarah indicated that she had tried to link individuals with particular expertise to some of our issue circles but it was sometimes not clear who was leading particular circles.

need for improved links between issue circles and rest of PHM

Maria reported from Central America. She commented that there was a long history of popular struggle in Central America, strong traditions of popular mobilisation and rich networks. Working in this environment the PHM activists had focused largely on building alliances with existing organisations, identifying them as/with PHM CA. Maria commented on the language barriers; she described PHM as very English-centric.

what a difference a strong cultural tradition of political activism makes

PHM has been very English-centric up until now

Maria reported that the Central American region believed that it was necessary to create a regional secretariat and, if other regions were of the same mind, there might be a much more limited role for any global secretariat, if such was needed. Perhaps the global functions could be distributed and the global coordination function might be carried by a coordinating committee based on the regions.

need to go to regional secretariats

distribution of global functions

global coordination carried out through coordinating committee representing the regions

Patricia commented that language was a major issue in Europe and that most of their meetings are conducted in two or sometimes three or more languages. She also commented on the transition from PHM being three individuals to the progressive networking with existing organisations, such as the Politics of Health Group. She commented that the POHG was mainly focused on national issues and perhaps not so aware of the global issues but that she expected that they would open up after attending Cuenca. Likewise the European Right to Health Group was being invited to come to Cuenca with the same expectation.

language an issue in Europe as well

patterns of development of PHM from individuals to organisation to networks

importance of PHAs to widen the awareness of some national networks

Andy commented on the process of institutionalisation and the significance of language, such as the use of the term 'circles' (in particular in relation to funding circles) to describe activities that were largely dependent on only one or two.

institutionalisation of PHM (structures not personalities) and role of language ('circles') in encouraging this

Delen's report on the Philippines experience echoed much of Maria's report. There is a long tradition of struggle, of networking and of popular mobilisation in the Philippines and PHM in the Philippines had linked into these long standing networks.

long tradition of political activism

PHM linking into existing networks

Delen also spoke about the region more broadly and reported on her participation in a recent meeting in Indonesia. It had seemed very promising at the time but since then no-one was responding to her emails.

some progress with respect to Indonesia

Dr Ekbal reported on the experience of PHM India. Like CA and the Philippines, India has a rich tradition of struggle and of networking. PHM India was built upon 26 pre-existing national networks which represented hundreds of more local organisations. This gave PHM India a very inclusive orientation which, however, was not always reproduced at the state level where often only one or two of the networks were represented leading to a kind of PHM capture phenomenon. Dr Ekbal acknowledged that the links between PHM India and PHM Global had given rise to some frustrations and needed further work.

tradition of activism makes a big difference

different characteristics of PHM India and the PHMs of the different states; perhaps more inclusive at the national level

Qasem commented on the Bangladesh experience which was similar to that of India, Central America and Philippines. He also spoke about the changing NGO environment in the region and the lack of regional networks and the challenges of mobilising in this context.

tradition of activism

challenge of organising the region; regional networks not so rich

Brigid spoke about the development of PHM in South Africa. She spoke about the cooperation between PHM and Equinet and the slow conversion of PHM SA from individuals to local circles. In many parts of the country there were individuals but no organisation. PHM SA has been targetting health workers around issues such as the brain drain and AIDS. PHM SA has sought to build an alliance with the Treatment Action Campaign but not without hiccoughs. It seems that the relationship is mixed. Brigid commented that the communications protocols of PHM were not working very well in igniting and facilitating campaigns. Zimbabwe has a number of individuals who are interested but they are not coming together as a group.

building local PHM circles as well as linking into existing networks (not always plain sailing)

Mwajuma, speaking for the SSA Region, indicated that this region will require continuing support from other regions and hopefully a global resource for some time. She appreciated the support that SSA had received so far from the Global Secretariat but was disappointed that previous talk of a mentoring program or placements for African activists in other regional centres had not eventuated. She spoke about some confusion over process and protocols for identifying contact and focal points. She indicated that she had felt a bit immobilised by requirements to observe democratic practice in situations where democratic choice was not really practicable.

Africa will require continuing support from beyond Africa

previous ideas for support to Africa (internships, mentoring) have not been realised

how to reconcile democracy with the need to get some structures in place?

The Lusaka meeting had been a great success. See attached papers. The relationship with Equinet has been very helpful.

Lusaka meeting a success

Equinet link very helpful

Mwajuma reviewed progress in Uganda, Tanzania, Kenya and Cameroon. She spoke about the challenge of developing a culture of activism in a socialist regime contrasting the Tanzanian experience with the culture of activism in South Asia. She also spoke about the expectation that NGOs have bags of money and the notion of a grass roots issue focused NGO was not widely appreciated. Language is a problem of course. The Charter has been translated into Swahili but translation of more everyday material is expensive. Many people do not have email access, let alone web access. Therefore we need to deploy hard copy materials and different communications modes.

challenge of developing a culture of activism in a cultural environment which is used to top-down control

language a problem in Africa

e-communication important but not enough; too many people do not have access to computers or to the internet

Ravi commented on these reports from the global secretariat perspective. He spoke about the reality of 'turf wars' and the need to negotiate these carefully in setting up a new network / organisation. He spoke about the strategy of linking with existing organisations and networks. He emphasised that PHM was not a branding exercise; rather it was a generic struggle which was by its nature inclusive. He spoke about the challenges faced at the Global Secretariat level of recognising or not individuals and organisations and chastised some members of the Steering Group for failing to appreciate and fulfil their responsibilities.

linking with existing networks (doesn't matter if they don't identify as PHM)

coordination challenges associated with the uneven growth of PHM

frustrations which reflect structural challenges

Cuenca Steering Group Meeting Minutes (2005)

PEOPLE'S HEALTH MOVEMENT

Proceedings of the Steering Group Meeting
held on
23rd July 2005 at Cuenca, Ecuador

(Based on notes of Dr. Thelma Narayan, PHM India)

Members present:

A. Steering Group
1. David Sanders (Southern Africa region)
2. Nadia (WGNRR)
3. Fran Baum (Australia region)
4. Pam Zinkin (Europe region)
5. Hugo Icu Peren (Central America and Caribbean region)
6. Zafrullah Chowdhury (GK)
7. Sarah Shannon (North America region)
8. Delen de la paz (South East Asia region)
9. Evelyn Hong (TWN)
10. Olle Nordberg (DHF)
11. Maria Hamlin Zunega (IPHC)
12. Arturo Quizhpe (South American region)
13. Qasem Chowdhry (Ex Coordinator and South Asia)
14. Prem John (ACHAN)
15. Ravi Narayan (Coordinator)
16. Mwajuma Masaiganah (East and Central Africa region)
17. Lanny Smith (North American region)
18. Hani Serag (Middle Eastern region)

Regrets

1. Bala (HAI-AP)
2. Mira Shiva (IPHC)
3. Samuel Ochieng (CI)
4. China region – no representation.
5. West Africa – no representation

B. Special Invitees / Observers
1. David Legge (Australia)
2. Andreas Wulf (Germany)
3. Maija Kagis (Canada)
4. Armando denegri filha (Brazil)
5. Bert de belder (Belgium)
6. Eduardo Espinosa (El Salvador)
7. Margareta Possada (El Salvador)
8. Julio Monsalvo (Argentina)
9. Patricio (Ecuador)
10. Mathura Shrestha (Nepal)
11. Dina Chaudhuri (Nepal)
12. Jose Utrera (Netherlands)
13. Ghassan Hamdan (Palestine)
14. Abdul Majid Makni (Morocco)
15. Unnikrishnan (PHM Media)
16. Xavier Montenegro

17. Nance Upham (Switzerland)
18. Thelma Narayan (India)
19. Claudio Schuftan (PHM Exchange)
20. Denise (Brazil)
21. Mohamad Ali Barzgar (Iran)
22. Ghassan Isaa (Lebanon)

Regrets

1. Andy Rutherford, UK
2. Andrew Chetley, UK

Have we left out anybody? Many had not signed the attendance sheet!

Introduction

Claudio Schuftan was invited to facilitate the steering group meeting and David Legge was designated as the rapporteur supported by a few other members (Thelma Narayan and others).

Claudio began by highlighting that four key issues would be the focus of the day's meeting. (The rather long agenda circulated earlier, had been modified due to shortage of time). These issues were:

1. Feedback on PHA2
2. PHM Organizational Review
3. PHA 2 Funding Challenge
4. PHM Global Secretariat
5. Any other matters

The meeting began with a welcome by the coordinator of the PHM Global Secretariat (RN). Because of a certain confusion about the membership of the Global Steering Group of PHM, he clarified who were members (formally) and who were special invitees and observers. He welcomed the 18 members of the SG – 6 network representatives (WGNRR, GK, TWN, DHF, IPHC, ACHAN) and 11 regional representatives (South Asia, South East Asia, India, Southern Africa, East and Central Africa, Middle East, Europe, North America, Central America, South America, Australia).

He announced regrets from Bala and Mira Shiva and Consumer International and informed that there were no representatives from West Africa and China regions. He also welcomed the special invitees, secretariat support group, and country contacts from over 20 countries and commented that because of the importance of the issues being discussed and the special opportunity of the Assembly – the steering group meeting had been further enriched by inviting country contacts and secretarial support group members as well.

1. Feedback on PHA2

A short feedback session on the just concluded Second People's Health Assembly was then facilitated. Strengths and weaknesses were identified by SG and different members

as organizers (as a prelude to a larger evaluation which would analyse the over 700 feedback forms that had been filled by participants in both Spanish and English).

The strengths identified were:

General

- Excellent experience
- Host country with strong people's movements
- Big success in spite of shortages of both time and money
- Positive presence of indigenous people, children, youth
- Greater visibility of people with disability
- Arturo's efforts and leadership great
- Inspiring event
- Inclusion of elderly
- Wonderfully inspiring meeting.

Logistics

- Very good social mobilization and support from local organization

Programme

- Amazing diversity of themes and participation
- Inaugural indigenous ceremony was very good and spiritual.
- Greater creative options like films, music, street actions

Impact on Follow-up

- Strong enthusiasm to work together on advocacy issues.
- Presence of new networks (PSI, Ahcc, EDAN Ecumenical and Disability), MDM, Latin American networks, etc)
- Good, strong media presence

The weaknesses were:

General

- Need for clearer focus on political economy and PHM strategy
- Problems of exclusion and politics in regions eg., Latin America
- Need better and more longer term planning for PHA3
- No position papers on issues circulated before PHA
- PHM globally coordinated campaigns should be on the agenda and more background papers for debate and discussion

Logistics

- Need for greater supervision of arrangements especially audio-visual equipment
- Logistical problems in arrivals, airport welcomes and local transportation

- Some harassment in hotels – not adequately briefed
- Day by day overview of activities not available; format of the printed programme not user friendly
- Need for information points for logistics
- Volunteers not organized, supervised, and coordinated adequately

Programme

- More debates around campaigns
- Difficulties in coordinating plenary and same-day workshops
- Chairs to be more proactive to prevent overlap of themes and presentation
- Many papers sent – not on the programme
- Organizational track given less importance in programme and choice of venue
- Plenary sessions too full of speakers to allow adequate participation from the floor!!
- Disability should be included in all sessions not special sessions
- Confusion between testimonies and presentations by panelists
- Traditional / alternative systems of Medicine should be mainstreamed and integrated in programme
- More in-depth analysis of Savar to Cuenca development and strategies should have been included.
- Too much inclusiveness leads to too many positions on a problem which further dilutes a strategic understanding for action.
- GHW document should have been distributed
- Lack of information about PHM itself in background materials and programme
- Gender issue missing in other tracks
- All thematic sessions should also focus on cross cutting themes like gender, disability, marginalisation, access, etc.
- Need to better design programme structure and time allotment.

Impact on Follow-up

- Not enough time to concretize action from workshops
- Not adequate time to discuss global Right to Health Care campaign
- Too much time on situation analysis, less time on collective action
- We have had Charter – PCH / Mumbai Declaration / HIV-AIDS Charter – but where was the follow up action reported at PHA2?.

Maria, Arturo and Ravi were invited to respond to some of these strengths and weaknesses.
Arturo mentioned that :

- planning and preparation had been democratic; one part-time person had been on the job for an year and in spite of language problem, responses to communications were within 48 hours;
- programme got overpacked because of inclusive policy and interesting and important proposals;
- there was a major problem of limited financing;
- tried to evolve a discipline and coherent working style in a large heterogonous team
- respected local and national organization committees;
- liaison with all government officials especially during Ravi and Maria's visits;
- Ministry of foreign affairs was open to us;

- we did not subject ourselves to local, national, international power structures when planning programme;
- company incharge of translations and equipment did not allow access to equipment;
- even though many organizations in LA were still not part of the movement, they attended and were allowed to make interventions;
- media teams work greatly appreciated.

Maria reported that

- all sessions were video taped and these will be given out and these will be available as DVDs on the last day
- all papers are being put together electronically and will go on website shortly.
- some of the programme problems were because PHM members did not respond early and promptly to programme related communications.

Ravi felt that these strengths and weaknesses identified, should be considered as lessons learn for next assembly.

- He felt organizational track should have had a central position because we are meeting as a movement after many years and all tracks should have had a strong PHM focus of action and campaign.
- Also in spite of our best efforts, there was still too much problems analysis and less discussion or reporting on actions or campaigns;
- part of the logistical problems were because of arrivals in three cities and the absence of adequate involvement of local PHM groups in the cities due to contracting out reception to an agent;
- some problems were caused by lack and delays in funding;
- many people who made presentations without power point made better impact – through stories, songs and passionate presentations and these were more symbolic of a people's assembly!

This session was wound up by a proposal by David Legge that a manual incorporating all these points should be prepared for the next PHA3. It should also incorporate all the feedback received from other participants as well.

B. PHM Organizational Review.

The summary document of the Organizational Review and options that had been prepared by David Legge and Andy Rutherford after the discussions at the steering group meeting in Bangalore in April 2005 were then discussed. This had been circulated in advance.

The summary document entitled "Building the PHM – Proposals for Consultation and Planning" which was a compilation of the Bangalore SG meeting discussions (April 2005) by David Legge and Andy Rutherford was discussed with a focus on the Tables in pages 11-13 of the document.

The facilitator outlined a evolving organizational structure and identified the main themes as follows:

i. How to improve global level PHM decision making

ii. How to improve governance mechanism
iii. How to prioritize regionalisation / regional capacity building.
iv. Clarity on central coordination functions.

Many ideas and opinions were expressed.

- There was an overall feeling that the existing steering group mechanism had not been that effective. There was lack of clarity on tasks and expectations of SG members especially since all were volunteers. Many did not respond to e-group decision making processes. Many were not clear whom / what constituency they represented.
- Some regions had special problems. Pam gave an example of Europe which was weak in PHM mobilization because it consisted of many countries, with language and cultural divides; many PHM members in Europe were in organizations that were not specifically eurocentric but more global in their outlook. Therefore, region specific strategies had to be evolved to make PHM grow.
- It was clarified by Ravi that presently from the Secretariat experience, around 7 to 8 regions were more viable than the original 13 regions considered in 2001. They were Europe; Africa; Middle East; South Asia including India; South East Asia including China; Australia; and the Americas which included North America and Latin America as distinct regions.
- Regions could be more autonomous; representativeness of all countries in the region should be gradually ensured; each region could have a regional coordinator.
- Instead of a steering group as at present, we could consider a global council of all the regional coordinaters who could elect / select a Chair who can rotate and one would also be the global coordinator of the council for each new PHM secretariat phase.
- The eight founding networks / organizations could re-mission themselves and also be represented on the council.

- Some additional support group members with specific functions like communication (web master) etc., could also be coopted to the council. No national representatives would be on the global council.

- A Transitional Advisory Committee could be set up to help this process of change in governance.

Some members raised dilemmas related to some of the above suggestions

- A continent may be too large and diverse to be a region
- Regional grouping should be decided by the regions eg., would Americas be 3 regions or two regions; would India like to continue as a separate region because of its size and its already being a coalition of 23 national networks and 17-18 State PHM Circles, etc.
- Will the council have bye laws and be empowered to co-opt some new members?
- Some regions like Europe are not happy with the regional secretariat idea and feel the need for a structure evolving more bottoms up. Presently they were considering Northern Europe and Southern Europe as separate divisions within the region etc.,

- Hugo had given some deep thought to the matter and suggested a complementary proposal which included:
  - A general assembly of the movement with representatives of all the participating countries who should meet as a governing body in all PHAs. Politically and strategically this is most important and it is easier to discuss policy issues at this level. (This would be 80-100 such representatives).
  - The assembly could be grouped into regions with coordinators to form a coordination council (this could be big or small – 13 to 7 depending on the number of regions retained.)
  - The Council is supported by a global secretariat with a global coordinator with an operational team along with members of issue based circles..
  - Hugo's plan was an effort to root the growth of a movement in a horizontal perspective rather than the more vertical, perhaps bureaucratic process we have at present. The main thrusts of his idea were on increase representativeness and the process of decentralization in the movement.

- Hani had some alternative ideas. He felt that since we don't have a clear cut membership policy, we will never be able to be too democratic in the selection of focal points at country and regional levels. Also the structure should not only be geographically based in a fixed steering group. We should aim towards developing a mix between country and regional groups and as well as campaign issues circles, both being represented in the governance structure. The number of representatives could be more flexible, different and diverse as circles evolve.
- Many members responded to Hugo's and Hani's suggestions on alternative structures. Comments included:

- There is need for a more specific critical review of the SG's effectiveness – who and why was not participating actively. Those non functioning should move on and be replaced by new representatives from those regions / constituencies. Some had already offered to retire.
- 6-7 regions are perhaps too narrow and not logical. This should depend on each region's opinion, provided they take responsibility and are logical and systematic in their approach.
- Along with regional coordinators there is a need to have a few PHM resource persons, who travel and mentor regions so that foreseeable asymmetry of regional development is addressed. **(Ravi and Lanny have been particularly good at this job).**
- Coordinators in the region should rotate every 2 or 3 years.
- While a general assembly is a good idea – it may be difficult to make it truly representative. Selecting a national representatives is not always easy.
- There is need to clarify further the issue of membership in PHM since many people question how to join PHM and also since we are more organized in some regions than in others, (also country level); we do not have good responses always.
- We must differentiate between 'upper' and 'lower' (PHM / phm). In many regions, we have long-standing networks and movements already. These are the lower case (phm). The new definitive coalitions we are forming since 2000 are the upper case (PHM).
- We should learn from other networks systematically building on past experience, eg., IBFAN, HAI, etc
- While decision making between steering group meetings is primarily through e-group mail – we must recognize technological problems that prevent some from active participation in some regions – Africa?. Also some issues need real time discussion as well since everything cannot only be discussed through internet.

- The Regionalisation process must respect how each region identifies itself, (language, concentric organizations, etc.)
- As our structure evolves, we must focus on PHM goals – impacting on health determinants from below – so we should focus on meaningful participation of community – therefore a loose and less bureaucratic governance is required.
- Also, people working actively (in the present) should be active in the governance of PHM with a clear purpose and continuity (not just past icons or leaders past their prime)
- The SG experience of 2003-2005 should be subjected to a SWOT analysis.
- There is a need for the structure to be strategic rather than only democratic – therefore too large an assembly will make it another conference by itself.
- The governance mechanisms should be practical without becoming too idealistic.
- There should be a mix of sectors represented and academics and researchers as well as social activists should be encouraged to work together without getting too ideologically strait-jacketed.
- None of us can represent our country in the real sense but like UN bureaucrats we should try to do so to the the extent possible.
- Overall the structure should be rational, accountable and democratic – perhaps using the existing model (Bangalore phase). With some changes it would work better. We do have some problems and we should attend to this proactively
- We should focus more on national assemblies and regional assemblies and think of national and regional steering groups as well to strengthen the movement from the base.

The discussions threw up several ideas and it was felt that a smaller working group should put it all together reviewing the feasibility of each of these ideas and suggest a process and schedule of change.

(It was decided to set up a small working group / task force to work on all these ideas on organizational structure and to evolve a framework of change. Four names were suggested – David Legge and Andy Rutherford who had already worked on a document based on Bangalore discussions, supported by Maria Zunega and Thelma Narayan if they were willing).

Before the close of this session, some members suggested further guidelines to help the small group in its organizational review and development of a strategy, which would then be discussed with a larger group – the SG and beyond, to bring about a consensus on the changes.

1. Smaller Global decision making body with supportive working groups (rational system??) and clarity of roles.
2. Viable regions and with coordinators and enhanced country level representativeness
3. Functions of Issue circles and clarity of when issues become campaigns and how they can be included in PHM's worldwide programmes.
4. Hugo's and Han's suggestions to be considered seriously.
5. National and sub-national mobilization focus to be emphasized to ground PHM at grass roots and community level!!
6. The organizational structure must be inclusive and responsive to help build the movement strategically.
7. Include a SWOT / critique of existing arrangements.

C. PHA2 FUNDING CHALLENGE

In the absence of Andy Rutherford, Ravi outlined the funding strategy and challenges that faced PHM in the context of PHA2 funding.

- Five funding partners had provided the main bulk of the PHA2 support funds. These included SIDA (Sweden) – 100,000 USD; Misereor (Germany) – 50,000 Euros); Cordaid (Netherlands) – 50,000 Euros; DFID – UK – through a Health Link project to support PHA2 media, website and communication – 44,500 USD; and CIDA (Canada) – 50,000 CAD. These five came to a totally around 300,000 USD.
- We had hoped all the plenaries and workshops would be sponsored (at least 5,000 USD each) but we received support grants only from WCC-Geneva (5,000 USD); Wemos, Netherlands (13,000 USD); AIFO – Italy (2,600 USD); Doctors for Global Health, USA (4,000 USD); Medico International, Germany (11,676.87 USD) and Save the Children, UK (9,400 USD); and Greenpeace, Europe
- Some specific grants included Action Aid (Asia) supported the region (10,940.67 USD), Action for India's Development - USA supported T-shirts and communication (5,250 USD); PAHO gave 20,000 USD for translation equipment: Novib and Medico gave 20,000 USD each for IPHU; WABA gave 6,250 USD for Latin America fellowships and PHM-USA raised support for some regional delegates (Latin America and South Asia). GFHR supported costs for pre PHA2 Research Forum.
- Two weeks prior to PHA2, we decided to support travel for around 75 resource persons from these funds – not exceeding more than three per country with a good geographical and gender mix.
- Arturo raised lot of local support including credit facility which was significant apart from some funds available through registration fees and meal coupons (still to be estimated).
- There has been an acute crisis, because of late receipt of grants affecting money flows and putting PHA2 organisers in Cuenca in some stressful situations (though unavoidable in the absence of any PHM reserve funds or endowments).
- The travel for African delegations to the tune of around 50,000 USD had to be advanced to enable African participation especially for the special plenary and this affected transfers to PHA2 local organizers.
- However, it must be noted that most of the regions also raised travel grants for their delegates from a variety of local fund raising and own sources in the spirit of a movement which was very creditable.
- Hesperian – USA also facilitated a credit card transfer scheme for small donations for PHA2 which raised some additional grants.
- The overall current estimated deficit is around at least 100,000 USD since Oxfam-Australia, CAFOD –UK, Christian Aid – UK, WHO-CSDH and some other agencies did not provide the grants we had requested.
- We have also managed with some loans from CHC Bangalore (PHM Global Secretariat host) and PHA2 Secretariat Cuenca.

- Some future possible grants are from ICCO (Germany), MDM (France) and other agencies.
- **All SG members and others were requested to raise money from their own known sources and contacts and partners in solidarity with PHM especially since PHA2 had been such an inspiring and significant get together. Most were also requested to support their own bills and those of some of their delegates from their regions as a special gesture wherever possible.**
- Armando suggested that he would try and raise 5,000 Euro from International Society of Equity and Health.
- Arturo also cautioned that there had been many unforeseen expenses and developments causing further deficits including some unpaid hotel bills, additional cost for computers, etc. An overall guestimate was that we needed 600,000 USD for a successful PHA2 and we had raised 450,000 plus already which was not too bad. But further efforts needed to go on actively.

Ravi cautioned that we had a complex arrangement of fund raising and accounts from OWA-UK, PHM Secretariat-Bangalore, PHA2 Secretariat – Cuenca; and IPHC Secretariat – Managua. These would have to be integrated to arrive at a final statement of receipt & payments and deficits. This may take a few weeks / months.

Maria mentioned that most of IPHU costs were met from the Novib and Medico grants and costs including support of faculty etc., were being calculated.

The discussion on this theme ended with

(a) a thanks to Ravi, Andy, Maria and all those who had helped with the PHA2 fund raising;

(b) an appeal to all concerned to make their own special and creative efforts in fund raising to meet the deficit as soon as possible; and

(c) for steering group members and some others to be a little more patient due to some expected delays in travel reimbursements.

PHM GLOBAL SECRETARIAT - next regional host and coordinator

1) Latin American Proposal

- Hugo presented a Latin American proposal on behalf of the region, which included the following features (supplemented by Margarita, Arturo and Maria)

- It would be a shared responsibility of the region in a collective way through a Latin American team supported by a coordinating council including national and regional councils.
- Arturo and Maria were suggested as probable coordinators.
- It was a joint Central and South American proposal.
- Meetings had been held in Argentina, Chile, Venezuela, Brazil, Ecuador. The meetings had discussed strategies not persons.
- GHW in Latin American had been a shared process of resource persons from 30 countries.
- The secretariat / coordination group would be run in a collegial way.

- It sould have a 3 member executive team who have 100% confidence in each other and would work together as a committee.
- Cuenca has infrastructure and Managua has experience. Arturo could support Maria and a chairperson could be from an other region. Decision would be by consensus not votes.

Many members asked for further clarifications and made comments and suggestions on this verbal Latin American proposal:

- To revitalize PHM, we have to do it with confidence. This proposal should have come 3 months ago so that we would have had time to decide and consider details more leisurely.
- Will there be one on two coordinators in the region? - there should be further clarity about shared responsibility.
- Can we decide on a verbal proposal or should there have been a shared circulated written proposal in advance.
- There are organizational guidelines circulated after Bangalore meeting. Have these been considered in the proposal – needed are a full time coordinator with organizational backing, with a communication officer; accounting expertise; infrastructure, etc.,
- Maria had categorically stated at the Bangalore SG meeting that she would not accept being a global coordinator under the present structure – is there a change in position?
- While it is legitimate for Latin America to take over the Secretariat, this proposal is not really a Latin American proposal since it has not been discussed earlier. There is need for more information and discussion about how it will actually function.
- A formal proposal should be worked-on and circulated to all SG members to help with the decision.
- The Indian region host of the Secretariat in Bangalore has worked well, has been very consultative and collective and has generated a lot of momentum. This should be maintained and built upon further by the proposals being drawn up in consultation with them and learning from their experiences.

2) Middle East Proposal

- Hani said that at PHA2, there had been some discussions on the possibility of another proposal from Middle East supported by the Africa region as well. This could be worked-on if there was more time and also only if the Latin American proposal was not considered feasible. Middle East would also be willing to put up a proposal for the next term – after this phase.(2008 and beyond)

3) Zafrullah and Nance suggested independently that the Africa region should be strengthened and the Secretariat should go there.

However, since it had been suggested that PHA3 would be hosted in the African region, perhaps it was also felt that it was early for the Secretariat function to go there as well now.

The session ended with the following two decisions:

a) It was cautioned that the process of identification of the next host of the secretariat and the coordinator should be by consensus and through a process that builds together and does not divide us further.

b) Secondly, it was decided that Fran would be requested to take receipt of both these or other proposals within a month (by 23rd August 2005) and help to build a collective consensus and decision on what was most feasible. The proposals would be circulated to all members of the steering group and a decision made before the end of September 2005 – so that a smooth transition from the India region (CHC, Bangalore) to the next region could be made.

FINAL SESSION

There was a group photograph session followed by the final session which included a discussion on the rest of the agenda with a special focus on PHM campaigns and follow up action after PHA2. The main issues discussed were:

- **PHM campaign / objectives** : It is important from past experience to be clear on what is an issue circle and what is a PHM campaign. All issue circles should put up a campaign proposal with specific objectives and strategies for and endorsement by the steering group or by a task group set up for that purpose.
- **Website management** – It was mentioned by Ravi that the website management needed to be taken up by another region since the Bangalore team would not be available beyond September 2005. Bert of Intal Belgium shared that they would be willing to consider this with Wim as manager. This was endorsed and Sarah (USA) and David Legge (Australia) also offered to help with this transition.
- **North American Representation** : The issue of North American representatives on the steering group (region consisted only of USA and Canada) need to be clarified. Sarah and Maija would represent it in future. Lanny would be invited to help Ravi with regional capacity building function.
- **PHA2 Proceedings** : There is need for a bigger PHA2 documentation (proceedings). All reports of workshops should be sent to the documentation team in 4-6 weeks (by mid September 2005). The work of Rebecca and her support team was commended.
- **Million Signature Campaign** : There was concerns expressed that we were not still able to enter the website and ascertain the numbers reached in the campaign. It was decided that all SG members would write to Unni to take this matter up with him on an urgent basis. Also the campaign group should be asked to present a more strategic schedule of the future of the campaign.
- **The Health Now – No War / No WTO campaign** : This was evolving well. There were three proposals from Palestine and 5 from Iraq to be added to the campaign.
- **Proposals on Trade and Health :** During PHA2, three proposals on Trade and Health were considered – by Bert (Belgium); David Legge (Australia) and Wemos (Netherlands). These could be reflected on the Health Now website.
- **Save Unicef campaign**: This had progressed well. Todd was commended on his efforts. Perhaps, they would now become a sort of Unicef watch and also become part of next GHW-2 process.
- **Global Right to Health campaign** : There had been many opportunities to discuss this at PHA2. Abhay and Claudio should update the proposal based on all the discussion and feedback ASAP and suggest / facilitate the next steps (action plan) in coordination with all those who have shown interest to collaborate. Especially link with the European and Latin American campaigns emerging on this issue.
- **Right to Water Campaign:** PHM should support the group from Canada (Anil Naidoo) who has initiated this. Hesperian could be the PHM contact.

- **WHO-CSDH**: Fran is playing an important role as Commissioner and needs all our support for advocacy and engagement with CSDH in whatever way possible at different levels and in different regions.
- **IPHU student projects :** The IPHU students had begun work on three projects (a) Trade and Health (b) Social Determinants of Health (c) Review of PHC concept and documentation of good case studies. These should be followed up and fully supported by PHM especially since they would build capacity and perspective among the next generation of activists.
- **Lets Write Peace Campaign:** This has been quite successful in getting school children to write post cards from many parts if the world. Should be followed up and supported.
- **Global Health Watch:** The GHW secretariat team were commended for their efficiency and enthusiasm that resulted in the GHW a CD release at PHA2 and so also the Latin American region especially Jaimie Breihl was congratulated on his successful initiative to produce a Latin American report.

All members were invited to support launches in their region and further adaptations or translations and the use of the advocacy document for local, national, regional initiatives.

- **WHO Advocacy :** The advocacy by WHO Circle in so many ways (especially Ravi and David's efforts) were leading to a re-endorsement / revitalization of primary health care. This should be highlighted on the website and the advocacy continued. The GHW Chapter on WHO should also be actively used for this advocacy.

Other Campaigns

- Evelyn flagged the small pox campaign which TWN would coordinate from their Geneva office. She had circulated background papers before PHA 2 and requested PHM to endorse it and participate in it especially at the next WHA (May 2006). This was endorsed.
- It was noted that Public Service International (PSI) had initiated a World Bank Watch and it was endorsed that PHM should collaborate with this initiative.

The Steering Group meeting ended with

(a) renewed thanks by all the members to Arturo and Maria and PHA2 IOC members and local PHA2 team for all the excellent organization, making PHA2 a memorable experience; and

(b) thanking and endorsing Ravi and his CHC/PHM Secretariat-Bangalore team for the excellent coordination and stewardship in the phase January 2003 till PHA2 Cuenca.

Cuenca Declaration (2005)

From communityhealth.in

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The Second People's Health Assembly (PHA2) was held in Cuenca, Ecuador from 17 to 22 July 2005 and was attended by 1492 representatives from over 82 countries. The **Cuenca Declaration** is the consensus document that arose from this Assembly. It reaffirms the continuing importance of the People's Charter for Health (2000) and endorses a vision of a socially and economically just world in

which peace prevails; a world in which all people, are respected, are able to claim their right to health and celebrate life, nature, and diversity.

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Preamble

Coming from 82 countries around the world, 1492 people met at the Second People's Health Assembly in Cuenca, Ecuador from 17th to 22nd July 2005, to analyse global health problems and to develop strategies to promote Health for all.
Overwhelmingly we reaffirmed the continuing importance of the People's Charter for Health (2000) and saw it as a rallying document for the ongoing struggles of the People's Health Movement globally and within countries.
The vision endorsed at PHA2 is for a socially and economically just world in which peace prevails; a world in which all people, whatever their social and economic condition, gender, cultural identity and ability, are respected, are able to claim their right to health and celebrate life, nature, and diversity.

Solidarity with struggles in Ecuador

Here in the heart of the Andes we have learned much from the hospitality, living cultural heritage, and current struggles of our Ecuadoran sisters and brothers. We join them in solidarity to oppose the signing of the Free Trade Agreement imposed by the government of the United States and the international financial institutions. This agreement will increase corporate profits, impoverish the workers, campesinos and indigenous peoples of the Andes, negatively influence their living and working conditions and impede their access to health care and enjoyment of health. We also join our Andean partners in opposing Plan Colombia, the name for the biological warfare carried out against them by the United States, which is poisoning their land and water, and militarising their border regions.

The global health reality

We deplore the worsening conditions of health experienced by many of the world's people and we denounce their cause - neoliberalism. Neo-liberal polices imposed by the G8, transfer wealth from the South to the North, from the poor to the rich, and from the public to the private sector. Corporate profits increase while poor people, indigenous peoples and the victims of war and occupation, suffer. Economically and politically generated health inequalities have increased, yet these root causes of avoidable disease and death are not effectively addressed by current policies or programs. The spirit of Alma Ata has been betrayed by most official health systems, though it has been kept alive in the face of adversity by health activists and health workers in community projects all over the world. Comprehensive primary health care is implemented in very few places, and the provision of health services is rarely seen as a collective social responsibility. Under neoliberalism there is no right to health, racism is nurtured, women's oppression deepens, social exclusion increases, environmental degradation becomes the norm, workers' rights are non-existent, and war serves the profit seeking of

big corporations. Governments, IFIs, WHO, multilateral and bilateral agencies are strongly influenced by the agendas of these corporations.

Establish the Right to health in an era of hegemonic globalization

PHM calls on the peoples of the world to mobilize against the denial of the Right to Health. The global economic framework of neoliberalism, privatization and "free trade," made operational through the WTO and international financial institutions, has played a determinant role in the transfer to the corporate sector of the control of the determinants of health. This leads to environmental destruction, toxic pollution, denial of rights to water, food, and life itself. The human right to health and health care must take precedence over the profits of corporations, especially the profiteering of pharmaceutical companies. The WTO operates as a de facto world government even though it is unelected, unrepresentative and unaccountable. Responsibility for international trade and development must be returned to the people through reappropriation of relevant UN bodies such as UNCTAD. Unless it is massively reformed to operate democratically, the WTO must be dismantled as it is a major source of massive human rights violations and injustice and a key mechanism of corporate control of life on earth.

The right to health will be achieved through large scale popular mobilization. PHM will initiate or support struggles related to the right to water, food security and food sovereignty, a healthy environment, dignified work, safe housing, universal education and gender equity, since people's health depends on the fulfillment of these basic rights. PHM will launch a comprehensive campaign to achieve the "Global Right to Health and Health Care" at the local, national and international levels, to defend health and social security (including health care) systems, and to document and oppose health inequities and denial of the right to health. PHM will defend health workers in their opposition to the privatization of health services by building broad multi-sectoral alliances.

PHM will campaign to end TRIPS, remove it from the WTO, and oppose bilateral Free Trade Agreements and TRIPS+. We call upon governments to use the Doha Agreement to provide people with affordable generic drugs. We oppose public-private partnerships because the private sector has no place in public health policy making. PHM will continue to monitor and provide inputs for the WHO Commission on the Social Determinants of Health to ensure that it effectively addresses the political and socio-economic causes of poverty, ill health and health inequity and engages in meaningful dialogue with civil society as much as possible. PHM will work with allied movements to coordinate common international actions against privatization and inequitable trade regimes.

Promote health in an intercultural context

PHM recognises that interculturality is a fundamental element to promote social equity and build a fair health system. Equity in access to health information is a fundamental human right. It is essential in the struggle for indigenous people's health. People's knowledge should be incorporated into the development of culturally based equitable health services; culturally sensitive prevention programs; the training of health workers in intercultural skills; achieving fair conditions of work; food security; and a healthy ecosystem. PHM will incorporate key issues such as the struggle against trade agreements, land reform and indigenous people's land restoration, protection against piracy of traditional knowledge as a fundamental defence of social security, cultural identity and nutritional security. The many useful aspects of traditional medicine and culture must be valued and included as part of a people-oriented society and health system.

Advance the right to health for all in the context of gender and personal diversity

The health of women, men and people of diverse sexual orientation is severely damaged by the dominance of a patriarchal culture with social and gender inequities and discrimination that affects their integrity. The social, health, sexual and reproductive rights of women are often denied. PHM commits to mainstreaming gender and feminist perspectives in all its work and action plans. Men and women of PHM commit themselves to deconstruct patriarchal relations in private and public life. This Assembly demands the dismantling of neoliberal policies that have increased gender inequality. To do so it will support international, regional and local campaigns for sexual and reproductive rights; strengthen communication and work relations with networks and other movements; and work to ensure safe abortion for all women and girls. PHM firmly denounces all forms of violence including

that against women, such as femicide, and demands government action to prevent it, to prosecute perpetrators and to provide all necessary support for people affected by violence.
People with disabilities and older people should be treated with respect and their right to appropriate health care should be ensured. PHM supports a new UN convention protecting and promoting the rights of persons with disabilities, promotes rehabilitation services as part of PHC, and urges the Commission on Social Determinants of Health to develop more focus on people with disabilities. PHM argues for the inclusion of people with disabilities in all aspects of life, and recommends that disability be addressed in a similar way as gender among donor agencies so that inclusive development is ensured. Protect the right to health in the context of environmental degradation
PHM calls upon the people of the world to support action to end imperialist control of the earth's natural resources and create and maintain a healthy environment for all. Natural resources essential to health are global commons. We call for a worldwide campaign for a UN Treaty on the Right to Water, ensuring that commodification and privatization of this vital resource - life itself - is both reversed and prevented. Guided by evidence of devastating damage and by the precautionary principle, we demand a moratorium on extractive mining and petroleum exploration/extraction, a ban on patenting of life forms and processes, research on nanotechnology, release into the environment of GMOs, and on development and use of all biochemical weapons. Governments are accountable to people not transnational corporations and must guarantee rights relating to health and the environment through enforceable laws and regulations. Governments, IFIs and the WHO must cease to be accomplices to TNCs and imperialism. Dow, Monsanto and other companies must be forced to provide reparations to the thousands of uncompensated victims of disasters such as Bhopal and Agent Orange. Knowledge and science must be reclaimed for the public good and freed from corporate control.

Ensure workers' health and safety by defending and extending existing rights

PHM calls upon the people of the world to demand the implementation of international treaties that protect workers' health and safety, recognize workers' health as a universal human right and a responsibility of the state, involve workers in the decision and policy-making process on working and health conditions and ban child labour. We support social arrangements to ensure the right to regular, meaningful and adequately remunerated work, with equal pay for equal work for men and women; protection of historical achievements attained by trade unions in the formal sector, renewal and strengthening of trade union, workers' and anti-globalization movements and their links to other movements; protection of the health of informal sector workers and migrants as they are more exposed to occupational health hazards; and universal health coverage through national health systems and insurance. Defend the right to health in the face of war, militarization and violence
PHM calls on the people of the world to oppose war and militarization as the most blatant attacks on people's health, especially the health of women and the poor. While the terror attacks in New York, Madrid and London caused unjustifiable damage, the US-led "war on terror" has generated an even more terrible, unjustifiable and endless war on defenseless populations in order to control their natural resources. At the same time, wars that have claimed millions of lives are unacknowledged as the UN system and our governments allow them to continue unabated.
PHM will continue to participate in the global movement to end the US occupation of Iraq and Afghanistan. Foreign troops should be removed immediately and reparations paid for damage caused by the US-led war. PHM calls for an investigation into the use of torture by US soldiers and medical personnel at Guantanamo Bay, in Iraq and Afghanistan, and an immediate end to the detention of foreign nationals held without trial at Guantanamo Bay. We demand that medical personnel refuse to participate in illegal detention and torture. The US and its allies must be charged with violations of the Geneva Conventions for their attacks on civilian populations, particularly medical personnel and institutions in Iraq.
PHM calls upon the United Nations and humanitarian agencies to intervene effectively in the "hidden wars" in the Congo, Sudan, Chechnya and many other places to foster lasting peace through political reconciliation and economic and social development programs that transform the social and economic conditions that give rise to these wars.
PHM opposes the Israeli occupation of Palestine and the efforts to isolate and ghettoize the Palestinian people behind the illegal separation wall. Denial of Palestinian health rights on the West Bank and Gaza has reached emergency proportions.

PHM supports the steps toward democracy and self-determination made by the indigenous people of southern Mexico, and calls for an end to the low-intensity conflict waged against them by the Mexican government.
PHM denounces the biological warfare called Plan Colombia currently being waged against the peoples of Colombia, Ecuador and Peru under the guise of drug control. These actions contravene international conventions, and irreversibly damage environmental and human health in the region.
PHM calls upon the United States to take responsibility for and compensate victims of Agent Orange in Vietnam, and the toxic contamination left by US military bases in the Philippines and elsewhere.
Struggle for comprehensive primary health care and sustainable, quality, local and national health systems
PHM recognises that neo-liberal policies have resulted in disinvestments in public sector health services; the promotion of a limited number of mostly curative technical interventions selected solely on the basis of a very narrow and often inappropriate application of cost effectiveness analysis, the corresponding neglect of broader environmental actions; the accelerated migration of health workers from public to private sectors and thence to wealthy countries; and the continuing spread of HIV/AIDS especially in Africa, with the collapse of public health services in many countries.
PHM calls upon governments to:

- Implement comprehensive community-based Primary Health Care initiatives that enroll or involve relevant sectors and are supported by legislation.
- Provide healthy living and working environments in order to respect and guarantee the health rights of all.
- Establish and fully implement universal health care financing mechanisms at national level in all countries (public health expenditure being at least 15% of the overall budget, especially in African countries) in order to provide protection for the whole population.
- Address the crisis of human resources for health (HRH) by: improving working conditions, training, support and supervision for health workers; implementing an International code of practice on ethical recruitment, financial compensation to exporting countries, return and reorientation of health workers in the diaspora through incentives, and establishing a global fund for HRH.
- Ensure widespread knowledge on HIV status; access to opportunities for voluntary testing; equitable, and sustainable access to ARVs with emphasis on prevention; comprehensive home-based care including health and social services.

PHM calls upon the WHO to support and promote the above as national government responsibilities and to advocate for the removal of economic and political obstacles at global, regional and national levels, that adversely affect national governments' social policies.
PHM will continue to raise awareness among communities on policies, policy-making processes and financial issues to enable them to monitor government performance, increase accountability and address health equity issues. PHM commits to gathering from within its movement, positive experiences of comprehensive PHC to build up the evidence base that supports such an approach, and to undertake concerted advocacy for its revitalization.
Finally, PHM salutes and supports the strong social justice approach to health in Venezuela and Cuba which inspires and encourages us towards Health for All.

Support the growth of PHM

The People's Health Movement is both a network and a movement that takes as its mission the strengthening of the much wider movement of individuals and organisations around the world fighting for the Right to Health. PHM is bound by a commitment to the People's Charter for Health and includes country circles, issue circles and affiliates which are actively involved in advancing the work of the PHM. Beyond this core of PHM activists are the friends of PHM and organisational partners at all levels. Another world is possible - these are our strategies to achieve it!
This declaration urges health activists around the world to organise, influence, advocate, analyse and educate to advance global people's health.

The People's Health Movement -

- will pursue work on the human right to health that includes both individual and community rights.
- will continue to struggle for improved ways of working by strengthening its regional as well as its global coordination. It will continue to develop participatory and transparent decision making so that activists at all levels know that their views are valued.
- celebrates the inauguration of the International People's Health University, a university for health activists with courses presented in association with local PHMs and selected universities around the world.
- will engage with formal training institutions and challenge the dominance of the biomedical paradigm of health care. It will incorporate diverse strategies for reorienting health worker education to comprehensive PHC, keeping people in communities at the centre.
- will become a forum within which intellectuals can support local activists in their action and struggle.
- will challenge the media to disseminate its perspectives and publicize its activities.
- will strengthen its communications strategy to reach communities at the grassroots.
- will translate as many of its communications as possible into two or more languages; will establish a mix of central and regional/national websites; the PHM newsletter will continue quarterly publication and will be translated into other languages.

As a summary of PHM´s strategy for the next three years:

- PHM will be linking the local, the national and the global by passing on and giving guidance to its geographical circles on the issues on which to concentrate tactically.
- PHM will document, analyze and disseminate research findings on key issues pertaining to the principles in its Charter, including gathering, analyzing and disseminating key evidence for its constituency of the efficacy and sustainability of initiatives in comprehensive primary health care.
- PHM will create awareness about the burning health issues of the day and will delegitimize and demystify false claims, prescriptions and slogans used by the Establishment.
- PHM will work with grassroots organizations and communities trying to understand their issues, building partnerships and supporting their activists in their struggle.
- PHM will adopt an approach of strengthening rights, and will support initiatives to achieve the Right to Health and Health Care at the local, national and international levels.
- PHM will work tirelessly to build international solidarity with the oppressed and with those affected by natural disasters and civil strife,
- PHM will confront powerful forces of oppression in the struggle for economic justice, in particular through support for cancellation of debt, the end of economic conditionalities and the establishment of a fair international tax regime.
- PHM will incorporate cultural and spiritual practices in all aspects of its work.
- PHM will advocate with national governments, UN and other national and international agencies to influence their decision-making.

The power of the People's Health Movement can change the world. Another World, which includes Health for All, is possible. We must all demand and struggle towards a world in which health is a right, and is not subject to the forces of neo-liberalism.

FROM SAVAR TO CUENCA VIA BANGALORE - EXPERIENCE OF THE PHM SECRETARIAT TEAM

Reflections on PHM Realities and Future Challenges[1]

Preamble

This background note is based on the experience of the PHM Secretariat team (hosted by the Community Health Cell (CHC), Bangalore, on behalf of the *Jan Swasthya Abhiyan* –PHM India) from January 2003 till December 2005. For three years, we were the coordination, organizational and communication hub of the PHM wheel with spokes spreading out in different directions linking us to the founding networks and institutions; the regional and country level focal points; the conveners of various PHM circles, initiatives and campaigns. We were also in touch with all the individuals, organizations, networks and campaign groups who wished to join or be associated with the PHM or wished to seek PHM's inputs, perspectives or partnership with their specific event, initiative, campaign or document.

This linkage was established primarily by receipt and processing of over 100 emails per day, supplemented by telephone calls, personal visits to the Secretariat, and by discussions with PHM secretariat team members during PHM and other events at country, regional and international levels.

To operationalise the challenges of these evolving linkages with their own agenda's, needs, requests and initiatives, the Secretariat team facilitated processes using governance and decision making structures evolved by the PHM before January 2003. These included the global steering group; geographical and issue based circles; PHM news brief, exchange and website; and an evolving PHM funding group.

In the process of this direct involvement, the secretariat team developed a first hand understanding of the reality of these structures, links, initiatives, campaigns. We also experienced the strengths, weaknesses, opportunities, threats, cross cultural and regional diversities and dynamics of the evolution of PHM globally. This note tries to identify and highlight some of the challenges and options and was a background contribution to the PHM transition process and strategy meeting held in Frankfurt hosted by Medico International from 6-9th of February 2006.

To stimulate discussion, this note does make some unavoidable generalizations and some provocative judgements – but all these are to be taken as a contribution to our current efforts at strengthening and sustaining the growth and evolution of PHM. We have enjoyed greatly this unique opportunity and

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[1] A background paper by PHM Secretariat team for the PHM Transition / Strategy meeting in Frankfurt, 7-8 February 2006

responsibility and have appreciated the trust, solidarity and support received from so many from all over the world. However, we also realize how privileged we have been to shoulder this responsibility so early in the evolution of the post PHA-1 movement building process. Recognising the importance of documenting this experience of the early organizational history of this global movement, we have evolved this short paper as a constructive contribution to the further development of PHM.

PHM AS A MOVEMENT!

a) A movement is not an international NGO or an international health institution or foundation. It is not just a network or coalition; a campaign or issue raising group; an event or project organizer. Neither is it a travel agency for resource persons to move from conferences, seminars or workshops from one region to another; a coordinator of meetings and or field initiatives at local, national, regional or international levels; a community based or community oriented project or organization or just a fraternal group of friendly people and organizations coming together for a good cause. What is it then?

b) Our three year experience with PHM helped us to learn, that a movement was more than all these put together, even if some of our time during these years, was spent on activities that fitted into one or more of the above categories.

c) The movement, as we understood it, was a growing and diverse collective process of evolving circles at community, country, regional and international levels of individuals, groups, organizations, networks and campaigns, linked by a commitment to the Health for All strategy, and to addressing the deeper determinants of health with communities and marginalized peoples through health action. The circles were linked by geographical closeness (country and region) or by a common concern leading to action regarding specific issues from the large 'Health for All' agenda.

d) The movement was circles not pyramids of decision making and common action, that were inclusive and not exclusive or ideologically straitjacketed; that built on trust, mutual respect, with an ethos of debate and dialogue; identifying common, shared concerns while accepting diversity and plurality of interpretation and strategy. These intersecting PHM linked country, regional and issue or campaign based circles were further woven together by a series of evolving charters and declarations that symbolized this growing consensus of shared concern and evolving collectivity, particularly focused on impoverished people and communities.

e) If PHM has to grow strong in any region, and develop in a healthy and sustained way, then country focal contact points and their groups or committees need to:

i. be inclusive in their networking;
ii. work with trust, mutual respect and a sense of responsibility for the movement;
iii. appreciate cross cultural diversity;
iv. be non-hierarchical and participatory in decision making ;
v. be patient and constructive in their circle building efforts ;
vi. develop their concerns and activities with people and communities.

Capacity building for the above is a necessary and important challenge for strengthening the movement further.

f) Some problems possibly due to a lack of these approaches were seen in Switzerland (PHM Geneva group), PHM Mauritius, some situations in PHM Latin America and PHM Middle East. The lack of capacity to network was seen in some countries of Africa and Asia, where circle building has sometimes failed to take off. Part of the problem included leadership styles; social skills; sometimes local political or ideological differences; but often members of founding networks were not necessarily inclusive, and had difficulty in donning the more inclusive PHM cap. Being inclusive, without being ideologically vague, is one of the biggest challenges for the PHM.

g) The movement was a new experience with no direct parallel for comparison and hence is a very exciting development.

Internal Audit

If the PHM has to grow in different countries and regions, then selection of contact points and focal points who have these and other skills and capacities are crucial. Alternatively strategies that help chosen contact / focal points at country and regional level to develop these capacities and attitudes may also be necessary. An internal review of existing contact points would be useful.

In some countries and regions ad-hoc, hasty selection of contact points without taking some of these capacities into consideration has led to a lot of time wasted, adversely affecting human relationships and bridge building. While the 'human relations' challenge is inevitable in collective efforts, problems are not always unavoidable. A small internal audit cum support group within the evolving PHM global or regional governance system will ensure that these issues can be addressed, without distracting or sidetracking the work of ongoing coordination, planning and movement building.

Auditors could be senior PHM activists or members who have shown these capacities in the past.

PHM VISION AND STRATEGY – WHAT AND HOW?

h) **The PHM Vision:** The Movement must have a Vision. The People's Charter for Health (PCH) 2000, and its two updates the Mumbai Declaration of January 2004 and the Cuenca Declaration of July 2005 articulate this

vision quite comprehensively. The People's Charter for HIV / AIDS released in Bangkok in July 2004; statements on Macro-Economics and Health, Public Private Partnerships, Trade and Health, Primary Health Care, Health Systems Research, Disasters (Tsunami) and the Politics and Power of Aid, the Researchers for Health Statement (PHA 2),; and a series of press statements by the PHM media group articulate evolving perspectives, responding to new international developments and challenges in health.

A 'Vision' Booklet

A small booklet or a section of the PHM website or both should be planned to increase ready access to PHM vision and perspective statements.

However, as an overall reference point the PCH now available in over 40 language translations will remain as

A Strategy Review

A small PHM strategy circle or perhaps the Research Circle should undertake an exercise to review the Charter, declarations, statements and press releases to evolve this booklet and to identify and respond to dialectics and perhaps inconsistencies if any. Vision clarity and its communication to various constituencies is important, and

Strategic Options – what does the Charter offer?

i) The real challenge to PHM is not vision but strategy and action. The challenge is to convert vision into meaningful strategic options at different levels to symbolize the content, direction, role, function and responsiveness of the movement.

An overview of the Charter highlights key strategic directions. In order of their appearance in the body of the Charter these include.

Health for All means:

1. "Challenge powerful interests and political and economic priorities of globalisation.
2. Encourage people to develop their own solutions.
3. Hold accountable local authorities, national governments, international organizations and corporations.
4. Demand that governments and international organizations reformulate, implement and enforce policies and practices which respect the right to health.
5. Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.

6. Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
7. Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalized groups.
8. Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
9. Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
10. Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.
11. Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.
12. Oppose international and national politics that privatize health care and turn it into a commodity.
13. Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organizing public health services so as to ensure free and universal access.
14. Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organizations in the World Health Assembly, and ensures independence from corporate interests.
15. Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
16. Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people and public health-oriented, respecting universal ethical principles.
17. Build and strengthen people's organizations to create a basis for analysis and action.
18. Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
19. Demand that people's organizations be represented in local, national and international fora that are relevant to health.
20. Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world".

This list is a selection from a much larger one in the Charters and represents those on which PHM has taken action or needs to do something urgently.

3. *PHM Current Strategies (2003-2006)*

By trial and error, through the steering group and in response to situations, PHM has evolved the following major strategic priorities over the last three years. Examples mentioned are those with which the secretariat has been more closely involved. There are other examples at regional and country level which are in the same genre.

1. *Building country circles around community and national needs, challenges and opportunities*
   i. These are ongoing in some countries by proactive country contact / focal points e.g., Bangladesh, India, Italy, Sri Lanka, Philippines, South Africa, Egypt, Palestine, Australia and many countries of Central and South America such as Ecuador, Guatemala, Argentina, etc. This should be enhanced by further recognition, involvement and capacity building of well selected country contact points.

   ii. Some country circles have been supported by visits of the global secretariat coordinator, steering group members and resource persons from the PHM who facilitated dialogue and workshops with potential PHM country circle partners, NGOs, academics, researchers and sometimes policy makers. In some countries, there have been more than one such visit – a PHM relay. These PHM relays have been effective in giving a boost or stimulus to country PHM circle mobilization. In USA, Iran and Pakistan, these have been primarily responsible for the establishment of the circle. This approach could continue as capacity building activities in the future. During the past four years visits were made to:

2002 - Kenya, Uganda, Tanzania, UK, Switzerland.
2003 - USA, Sri Lanka, Norway, Sweden, Netherlands, Germany, Iran, Italy.
2004 - Pakistan, Thailand, Mexico, Mauritius, Australia, Lebanon, Germany.
2005 - Chile, Ecuador.

Towards a regional capacity building team

The outgoing coordinator, some steering group members and resource persons who have shown an aptitude and skill to undertake this inspiration / mobilization task at country and regional levels should be formed into a regional capacity building circle, and supported to do the same in coordination with country and regional contact points in the future.

iii. PHM India, PHM Bangladesh have very strong, ongoing movement building experiences that need to be more widely shared. The collective effort of over 20 national networks learning to work together as PHM India; people's health tribunals; strong engagement, health policy work and health watch efforts with government health programmes; and decentralized district level PHM mobilization in Bangladesh are all inspiring examples of relevance to other countries.

2. *Building Regional Circles around regional needs, challenges and opportunities*

- Some efforts have been made in East Africa; Latin America and Middle East, and in Asia.
- These need to be strengthened and could be an important adjunct to the process of increasing PHM participation in World Social Forum and Regional Social Forum processes. The opportunities to PHM provided by WHO-CSDH for facilitating dialogue with civil society can also be used to strengthen regional circles.

3. *Facilitating PHM representation, participation in local, national, regional and international fora and meetings*

There is regular input/involvement in the:

- World Social Forum,
- Regional Social Forum,
- World Health Assembly,
- Annual Forum of Global Forum for Health Research,
- Health Promotion conferences at regional / international levels,
- Canadian Society of International Health meetings,
- Meetings of National Public Health Associations,
- National, regional, international HIV-AIDS conferences and meetings.

In many of these conferences PHM resource persons have been on specific panels providing opportunities to raise PHM concerns and perspectives.

In several of these meetings PHM related participants have taken the initiative to organise special lunch time seminars or informal meetings for those interested in PHM so that they get an opportunity to meet the PHM participants, learn about the movement and join the movement if they are interested.

These proactive efforts need to be strengthened and increased so that PHM concerns and perspectives are more widely shared and the movement grows increasing its outreach and impact. Some mechanism and guidelines by which organizers / panelists participating in these events report back to PHM through short reports featured in the PHM exchange and the PHM website are crucial to ensure that the learning experiences are more widely shared. Regular reporting will also inspire more PHM related participants at such meetings to take the initiative to promote PHM concerns and perspectives.

4. *Evolving an advocacy strategy to bring WHO back to Health for All perspective and goals and to focus action on health determinants.*

The WHO-WHA advocacy circle in close coordination with the Research circle and the Global Health Watch group have very effectively advocated with WHO at different levels and through different strategies making them more open, responsive and keen to engage with Health for All goals and PHM concerns in particular. As of today, this strategy includes:

i. Regular and increasing proactive participation and advocacy in the annual World Health Assembly,
ii. Regular and increasingly proactive participation in the Annual Research Forum of Global Forum for Health Research
iii. Involvement with WHO Commission on Social Determinants on Health at all levels. PHM has a full Commissioner as well.
iv. Informal and formal advocacy including submission of position papers / policy briefs on areas of WHO concern and PHM interest.
v. Participation in WHO meetings including more recently the consultation on WHO General Programme of Work (2006-2015) and the earlier Madrid consultation on Primary Health Care Policy, etc.
vi. Participation by WHO team members at HQ and regional levels in PHM workshops and meetings including the Second People's Health Assembly.
vii. Increasing dialogue by PHM at regional levels with PAHO, EMRO, AFRO, WPRO and SEARO. All are beginning to show interest, with PAHO leading the way with excellent examples of dialogue and partnership.

PHM Advocacy with UNICEF / World Bank / Global Fund

Similar to the PHM WHO Circle efforts with WHO which are beginning to bear some results – PHM should actively evolve advocacy strategies with UNICEF and World Bank and perhaps the Global Fund as well. The Save UNICEF campaign was a starting point vis-à-vis UNICEF but this could now be converted to a PHM-UNICEF Watch. Similarly a group or circle that will monitor, watch and engage if required with World Bank. Health activities and Global Fund as well should be urgently considered.

5. Building Global Solidarity through regular participation in the World Social Forum and Regional Social Forums

The WSF processes (both global and regional) provide a unique opportunity for PHM to dialogue with larger global social movements and apart from supporting them also adding or strengthening the health related agenda in their movements. The People's Charter for Health has calls for action that are so comprehensive that they very easily allow this form of linkage or complementary relationship.

- PHM participation in the main events with two or three workshops or creative events have become a regular feature of the WSF and regional and country forum's that precede the global event.
- In 2002, 2003 and 2005 PHM also participated in the International Health Forum in Defence of Peoples Health in Porto Alegre, Brazil and in 2004 at Mumbai – it hosted the Third International Health Forum (see Mumbai Declaration, January 2004)
- In 2006, PHM is participating in all the three policy centric WSF in Caracas, Mali and Karachi.

PHM links to the Social Movement

A Circle to enhance this linkage and dialogue of PHM with the social movements has been suggested. Given the nature of the events and the culture of the WSF process. Some groups and networks are regular participants of WSF process and they could be involved to operationalise the PHM – WSF circle and

6. Global Right to Health Campaign (since 2004)

This has evolved through consultation at various levels, an extensive campaign with People's Tribunals organized by PHM India, and meetings

at WHA and other fora with the UN Special Rapporteur on Human Rights. At PHA-2, after extensive discussion the global campaign was launched. Efforts are on now to get around 20 country PHM circles involved, adapting the campaign to local opportunities.

7. Disaster and Humanitarian Responses

- The PHM War, Disaster and Humanitarian Circle has been active raising issues and promoting collective initiatives during the build up to the Iraq war, and during the tsunami (South Asia), earthquake (Iran) and some Latin America disasters.

- The Tsunami statement on the politics and power of aid (April 2005), several press statements, the post BAM earthquake initiative, the Tsunami Watch project etc., are examples of practical initiatives that have greatly helped to enhance the visibility of PHM and also symbolize a responsiveness of the movement.

8. The active participation in the Annual Research Forum organized by Global Forum for Health Research (GFHR)

The WHO-WHA Advocacy Circle and the PHM Research Circle have been very effective in raising the profile of PHM in issues of relevant research important for People's Health in the annual forum's organized by the GFHR.

These have included:

- Presentation and participation in panel discussions at Annual Forum on Research priorities and issues from a PHM point of view.
- Facilitation of a NGO Civil Society Dialogue on Health Systems Research
- Articles and view points in Lancet and BMJ and other key journals.
- Very strong participation and inputs in the Mexico Health Research Summit, November 2004 (18 participants from PHM) which also impacted on the Mexico Declaration and led to PHM now being represented on the GFHR Foundation Council.
- GFHR also supported a Researchers Forum (dialogue with researchers) as a pre PHA2 satellite event which resulted in a small booklet released in Forum 9.

9. The International People's Health University (since 2005)
   - From January 2004, PHM has been seriously considering a proposal for regional capacity building and training of younger generations of activists for PHM involvement in the future.
   - In 2004, IPHC – one of the founding networks initiated a process towards evolving an International People's Health University Project which will facilitate such perspective/capacity building processes linked to international and regional events associated with PHM.
   - At PHA-2, the IPHC facilitated the first IPHU session from 10-16th July 2005, with 60 participants from around the world (2/3rd from Latin America).
   - The Frankfurt meeting will also be an opportunity to review this initiative further and plan its future content and strategy.
   - The challenge to the IPHU initiative is to harness and involve all potential academic, research and training centres within the global and regional PHM circles in this international training initiative.

10.Communications and Campaigns

PHM has evolved a communication strategy to keep all its members informed about all that is happening within PHM circles at country, regional and international levels.

This includes:

a) PHM Website;
b) PHM Exchange
c) Regular News-briefs every 3-6 months (we are now moving towards a double bumper issue News-brief 16-17 - which will cover PHA-2 at Cuenca and the transition process),
d) A set of increasing PHM publications at national, regional, and global levels,
e) A set of audio visuals –video cassettes and CDs (see separate list).

It has also evolved campaigns from time to time which include:

a) The Million Signature Campaign (January 2003 Asia Social Forum), Hyderabad
b) No War, No WTO, Health for All Campaign, January 2004, IHF / world Social Forum, Mumbai
c) Save UNICEF campaign – March 2005
d) Women's Access to Health Campaign – Annual campaign of Hesperian, WGNRR of which PHM is a co-sponsor.

(see section on Issue circles as well)

Other campaigns and smaller initiatives have been initiated from time to time because of the enthusiasm of some PHM members but it is necessary to review them and decide on the following as a PHM campaign policy.

4. GLOBAL GOVERNANCE AND DECISION MAKING IN PHM

a. The Global governance and decision making process in PHM includes three components:

I. A global steering group which consists of
   i. A group of founding networks and organizations
   ii. A group of regional focal points
II. A Global Secretariat with a coordinator and a secretariat support group.

I) Global Founding Networks and Organisations

Issues of Governance in the context of Founding Networks and Institutions

1. All founding networks and institutions have played a crucial role in mobilization for and organization of PHA-1, in the formation of the concept of PHM, and early governance, structure and initiatives of PHM.

2. Now in 6th year of the Movement and based on the experience of 2001-2005, there is need for clarity in each of these eight networks on
   a) Area of support and focus
      - Technical – What issues of interest?
      - Regional – What regions; Where strong membership, Who could be involved?
      - Organisational (support to secretariat function) – Which function if any of Secretariat global / regional contacts will they support?
   b) Need to move beyond individuals / icons of these networks to more institutional / network policy linkages.
   c) Need to build PHM projects / related initiatives including funding support into their annual / perspective plans of action and budget of each of these networks.
   d) Clar5ity of identity with PHM at all levels – national, regional and global

3. a) Larger issue for policy review
   a) Should founding networks or organizations continue to be represented in the Steering Group separately or should they merge into regional& country level coordination and representation?
      If they continue then for how long? Till PHA-3 or permanently?
   b) What should the PHM governance response be to inclusion of other global networks like IBFAN, IFMSA, WSHF, FOE and others (who could be considered in the same way as the original 8) as new partners?

ii)

Apart from the eight member, representatives of the founding networks and organizations the global steering group in the last few years 2002-05 has also consisted of 9-13 additional members who were representing the thirteen regions into which all the original 75 countries (represented at PHA1) were divided. A SWOT of this component of the steering group membership and contribution is as follows:

i. The regions which had a representative (focal point) where South East Asia, India, Southern Africa, East and Central Africa, Middle East, Europe, Central America and Caribbean's, South America and Australia, New Zealand & the Pacific.

ii. North America had two US representatives and PHM USA was facilitated jointly by the Hesperian Foundation and Doctors for Global Health and the absence of a representative from Canada was an additional factor. Further West Africa and China had no representative even though we tried to get WGNRR, (Cameroon) to stand in as a contact point. South Asia had Qasem, even though he was also ex-officio because he was the outgoing coordinator.

iii. Efforts were made to specify the countries allotted to each region and help the focal points initiate regional networking among the contact points of the countries in the region so that they would enhance their representativeness on the Steering Group. This representativeness was enhanced in East and Central Africa, Southern Africa, Europe, India, Australia-New Zealand and the Pacific and Central America and Caribbean's. This was less successful in South Asia, South East Asia, South America and in the absence of focal points not possible in China and West Africa region. However, the efforts in the Middle East region were probably the most effective.

iv. Apart from representativeness, the real problem experienced was responsiveness. In spite of setting up a steering group – yahoo. Group for governance and decision making convenience, that was efficiently moderated by Maria – many SG members neither acknowledged the communication nor provided responses to decision making options or queries on matters of PHM planning and policy. Some complained that the secretariat sent too much mail and too often but any changes in size or number or even labelling them as alerts; needing priority attention; just communication etc., failed to enhance adequate participation. The few who did were mostly representatives of other networks and hence were sympathetic and responsive to the process of communication.

v. We included all the members of the secretariat support group on this yahoo group. They were not steering group members officially but were volunteers who had offered to support the secretariat in specific functional areas and some others who were convenors of issue circles. On the whole, these volunteers were more responsive than most of the steering group and this was very supportive of the secretariat team's morale.

Evolving strategies for organizational communications in concentric circles

There is need to have concentric circles of e-group listing to enhance various levels and degrees of decision making and or enhance internal communication in PHM. This may involve the following circles

- a core for decision making; a core + secretariat support group;
- a core + secretariat support group + country contacts;
- a core + secretariat support group + country contacts + campaign issue circle convenors.

If regional coordination is to be the way forward in the future than yahoo groups in the regions with similar levels of listings may have to be evolved.

vi. Most regional focal points with the exception of Latin America / Australia and North America did not evolve any mechanism to communicate with country contact points in their region so this responsibility became an additional burden on the secretariat team and often we had to send it to everyone directly with no amplification or support from the regional focal point. Hence, potential strengthening of regional level communication strategies did not take place as widely as we had hoped.

vii. Enhancing regional coordination is an important organizational imperative not only to reduce the overall burden on the inevitably small global secretariat team but also to enhance responsiveness, regional decision making, regional capacitation and regional communication. With the exception of Middle East and Central America which were good even before PHA2 and probably North America and Australia and Pacific after PHA2 this capacity will take some time to build in the different regions. Hence, while a collective regional coordination (a horizontal structure of equal regional coordinators) who work complementary to each other such as in HAI or other networks is an excellent proposition and definitely the way ahead, the presence of very unequal regional capacity at present will require some proactive global coordination or convenorship for some time to come. In the absence of such global coordinatorship – often proactive, bridge building, linkage promoting and opportunity exploring, the movement will just disappear or collapse in some regions today.

viii. The choice is not simply global –vs- regional coordination but an active regional capacity building strategy by a global coordination council / secretariat as pro-requisite to a more horizontal governance structure in the future perhaps operationalised before PHA3.

ix. The number of regions (original 13 of November 2001 proposal) has been found to very unrealistic and unwieldy in terms of organizational efficiency and support to decision making processes.

x. Eight or Nine would probably be more feasible and practical especially if we are also going to consider finding more full time regional coordinators who have an NGO in the region backing them up with supportive services as hosts of regional secretariats.

xi. Finally, while deciding on the number of regions and distribution of countries – the transition team must recognize some regional processes that have been strengthened particularly in the mobilization phase towards PHA2. These should be recognized, respected and strengthened further. Key among these ongoing are:

a) **Africa region**: The regional meeting of Civil Society in Health organized in Lusaka, Zambia in February 2005 brought together many Africa based networks including PHM Africa. The group helped the mobilization process for PHA2 and helped evolve the special plenary on Africa at PHA2. A five member group facilitated this and at PHA2 and thereafter two members have continued to support the process including the interaction with WHO-CSDH in the region. It is important to take this process forward after reviewing the experience of 2005. This is particularly important because several efforts in 2002, 2003 and 2004 of PHM resource persons trying to facilitate regional and country level meetings as promoters / visitors from other regions failed to take off. The more local effort in 2005 seemed more feasible.

b) **Middle East in Region** – the region has been mobilizing as a regional group for many years but their efforts got a boost with preparations for PHA2 and the WHO-CSDH process thereafter the proposal for hosting the secretariat that evolved from the region after PHA2 had a very good regional process / movement building plan. While coming to terms with inclusion of Iranian PHM and perhaps people's health group in Israel as well in an inclusive way as also North Africa, the regional process needs to be strengthened with focus on PHM circles at country level. Perhaps hosting the global secretariat will enhance the regional capacity as well. There is a lot of country level potential particularly simultaneously is Egypt and Lebanon that can be tapped.

c) **North America** – PHA2 mobilization and the actual event has led to great strengthening of PHM mobilization in USA and Canada and much greater potential for a North American regional dialogue and joint planning. At Forum 9 in Mumbai –PHM Canada organized an informal meeting as well and PHM USA has also been moving from strength to strength. There is great scope for the North American region of PHM becoming a strong resource group for International Health Advocacy as also a funding support partner for PHM especially supporting regional initiatives.

d) **Europe Region** – the paradox of PHM Europe has been that it is among the strongest resource groups of PHM – the funding operations are facilitated there; the Charter translations are tracked; the Global Health Watch 1 secretariat was based there; the annual Women and Access to Health Care campaigns are facilitated / coordinated from there; the early communication efforts were supported from there; PHM members in Netherlands, Germany, Switzerland and Italy are strong supporters / participants of all PHM events and initiatives etc., etc. But country circles focused on local Health for All challenges are not yet getting established. More recently, the evolving network regarding the movement against privatization of health care with strong trade union roots and European, Social Forum linkages is a good step to shift focus from international solidarity effort to local country level health action. The discussions among PHM Europe region contacts has also led to the identification of language and cross-cultural challenges in the European region. The North and South of Europe and perhaps East and West have their own challenges and PHM Europe region has to tackle the challenge of bringing together nearly 46 countries with all their diversity. A growing link between international solidarity group and local HFA action groups especially

among the trade unions and radical professional groups may be a good way ahead to strengthen further the PHM in the region.

e) **Australia, New Zealand and Pacific** – the Australia PHM has been steadily evolving for the last few years with a boost following the interactions by the PHM resource group from other regions before the Melbourne conference in 2004. The mobilization for PHA2 further strengthened the links with indigenous people and some extension of linkages with New Zealand also took place. Other island country contacts need to be identified and the regional activity further strengthened. The PHM OZ website has been an inspiration. It could be a vehicle for stronger regional networking.

f) **Asia** – originally divided into four regions (South Asia, India, South East Asia and China) Asia has had a mixed regional development. The presence of HAI-AP, ACHAN, CIROAP and TWN and the strong PHM movements in Bangladesh and India have meant that Asian PHM circles have been meeting quite often at various network meetings and regional workshops and at the Asia Social Forum and other key meetings. Country circles have developed to varying extents in Nepal, Pakistan, Sri Lanka, Philippines and are evolving in Malaysia, Indonesia, Cambodia and Thailand. Progress in Vietnam, Myanmar, China and Japan is poor. Regional UN organisations like UNESCAP and WPRO and SEARO have been slowly beginning to recognize the PHM in Asia as a resource. UNESCAP involved PHM in orienting its new health unit team and also in evolving its health policy for Asia.

However, a regional identity of PHM as PHM Asia or even PHM South Asia and PHM South East Asia is yet to emerge. This needs to be constantly worked upon building the resources and opportunities provided by various Asian Networks already interested in and supporting PHM. The enthusiasm of evolving the People's Charter for HIV / AIDS and the evolution of APPACHA was a good initiative but like many others lost some steam along the way. WHO-CSDH-CSO Initiative in India and Bangkok and WSF Karachi (March 2006) offer good opportunities.

ACHAN which has been dormant for a while, but now recently, more involved with Tsunami Watch and also PHA2, should be revived to play a much more significant role with probably younger leadership. A concerted effort by all the five networks in Asia –HAI-AP, CIROAP, ACHAN, TWN, ASF and supported by strong PHM country resources in India and Bangladesh could lead to a region strengthening strategy. This is urgently required. The WSF in Karachi in March 2006 and the next National Health Assemblies in Thailand 2006 and India 2007 may be opportunities for such cross regional efforts.

g) **Latin America** – these includes the PHM regions of Central America and the Caribbean's and South America. The regional mobilization has been historical and strong even before PHA1 and now recently for PHA2. But the region faces some important challenges

- the language diversity – Spanish and Portuguese is a challenge
- the high degree of political awareness and complexity provides a challenge for the issue of PHM inclusiveness and the secretariat has received in the last few years the largest amount of feedback on this matter and has found it not an easy matter to address.
- the region is one of the most inspiring of the PHM regions for the wealth of movement experience including the growing indigenous people's empowerment, and the phenomenally

creative culture of protest and celebration, as was evident at PHA2.

- Latin America has so much to offer other regions if some of these complexities could be transcended and the global coordinatorship which was already available for the PHA2 organisation further extended for the next phase.
- The recent political changes with a growing axis of good – Cuba, Venezuela, Bolivia, Chile, Uruguay, Argentina offers a larger regional context of change that makes PHM more meaningful and viable in the region.

In conclusion, there is great potential and possibilities in enhancing regional coordinating both as a concept and thrust of PHM in the next two years building on the ongoing processes discussed above. This should be done however with a specific focus of regional capacity building by a catalyst team which can do it in a participatory, facilitatory way enhancing local effort and local creativity. It will not happen spontaneously so some global planning even to facilitate a group of people who will do this activity in a focused committed way must be operationalised fairly soon.

c) Global / Regional Secretariats and steering group

Guidelines relevant to a PHM global secretariat were evolved in November 2002 at Gonoshasthaya Kendra, Savar – Bangladesh, (PHM steering group) before the shift of PHM secretariat to CHC, Bangalore. These have been circulated (January 2003). Also, how these guidelines were operationalised by the Bangalore has also been circulated (to help Middle East and Latin America understand the dynamics / challenges of global coordination while they were evolving proposals to host the global secretariat.

In this report, we shall not go through these points once again since those documents can be referred to suffice to. A few general points relevant to global or even regional secretariats are included here.

The concept of a global secretariat with a full time coordinator and a small team of communication officer, secretariat assistant etc., was a necessary aspect of the phase 2002-05 because the PHM was an evolving concept and movement. However as the movement has grown rather unexpectedly both in visibility and in terms of demands on global secretariat teams this is not a viable proposition now.

a) A large number of activities / responses / functions presently carried out by the global secretariat and coordinator can be better done perhaps more effectively by regional coordinators if they have the capacity and aptitude to be inclusive, representative and responsive. Funding a larger number of regional NGOs who will support regional secretariats and perhaps even provide a senior team member to do the temporary (part time job) of a regional coordinator may be easier than trying to

identify a global coordinator in a region to do the job the Bangalore team did.

b) CHC Bangalore had a rather unique history of networking and movement building in India and later South Asia for over 2 decades, resulting in facilitation of some significant aspects of PHM India mobilization. They also had a senior team member like Ravi Narayan available to be full time on this global assignment. The coordinator of the global secretariat had the full support of CHC team since support to PHM secretariat and process was one of its key initiatives for the phase. So its funding partners were also supportive, as were PHM resource persons from the region. This led to an unusual combination of supportive factors not easy to find in every hosting region willing to host the secretariat.
c) So new approaches may be required. One of this enhancing is regional coordination with supportive NGOs hosting regional secretariats and providing at least part time coordinator who can work together as a global coordination council.
d) Whether global or regional secretariats some factors need to be looked into as we evolve responsive governance structures at all these levels including steering groups or coordination council
e) All global or regional steering groups or coordination groups or coordination councils or (whatever the new nomenclature) must have chairpersons so that coordinators are not expected to do both executive and convening roles, which can be conflicting.
f) As a general rule, steering groups should not consist of icons or very famous or well known resource persons. These should be on advisory groups. Efforts should be made in a concerted way to identify and foster younger leadership in all regions who can be more responsive and creative to the current situations.
g) All councils or steering group members should have limited periods on the group / council – never more than 2 years so that there can be rotation of responsibilities and 'new blood' all the time.
h) Some watch on 'representativeness' and 'responsiveness' of council or steering group members must be maintained to enhance the potential of PHM mobilization at every level.
i) While funds and other forms of resource support may be provided from the global budget of PHM to support, kick start or facilitate regional mobilization and capacity building – regionalisation should also focus on regional capacity building which should ultimately lead to regional capacity to plan, organize, raise own resources and evolve local governance and advisory structures without too much reliance or dependence on global effort / coordination.

4. ISSUE CIRCLES

The experience of the secretariat in supporting / facilitating issue based circles and campaigns have been very diverse.

i. Only three circles the WHO-WHA Advocacy Circle; the Research Circle and the War and Disaster Circle have been consistently active and responding to requests, events and evolving some collective initiatives around World Health

Assembly; Global Forums for Health Research and Natural and man-made disasters respectively helping greatly to enhance PHM visibility, relevance, contribution and to some extent impact as well. The membership of these circles has been varying, some events / initiatives linked to the circle activities getting more responses and participation than others. However, even these three circles need to plan their communications on the PHM Exchange and PHM website in a more coordinated way to interest new members in their activities.

ii. Efforts to facilitate a PHM – HIV/AIDS circle after the UNAIDS request for a dialogue in 2002 and the interest shown by WHO with its 3 x 5 initiative to dialogue with PHM around IHF/WSF Mumbai, January 2004 saw some activity leading to the development of the People's Charter for HIV / AIDS before the Bangkok World AIDS Conference. However, this circle has been somewhat dormant since.

iii. A Macro-economics and Health Circle worked on a statement / PHM position on Jeff Sachs report. This was circulated at the WHO regional dialogue with Civil Society in Colombo (SEARO and HQ initiative).

iv. Politics of Health – IPHC had offered to host this circle since it was central to their contribution to HFA before PHA1 and as PHM evolved. But there has been a lack of clarity about this circle and how it differs from IPHC itself.

v. Disability and Economics Circle – a meeting was organized at one of the GFHR fora and there was some interest in many.

vi. **PHA2 – An international organizing committee (IOC)**: This was set up to help with PHA2 organisation and mobilization. After an initial well planned meeting between IOC and the local /national committee in September 2004, the PHA2 Organising Circle / IOC failed to work as an effective supportive circle. Hopefully, the PHA2 review that is expected soon will try to explore and establish factors and learning experiences for this inadequacy, which greatly affected the pre PHA2 developments and increased the load on a few people left to handle the responsibility.

vii. More recently, Global Health Watch, Global Right to Health Campaign and WHO-CSDH dialogue with PHM are three PHM related activities which are evolving into relevant and perhaps effective circles of PHM members working together.
The presence of an efficient secretariat team in the GHW1 context; the presence of consistent interest and initiative in GRHC context and the presence of a full time PHM Commissioner on the WHO-CSDH and strong PHM supporters in the CSDH Commission have been responsible for the evolution of effective circle like developments.

viii. **PHM Communication Circle**: The idea of bringing together PHM resource persons and secretariat support group members who help with communication, Website, News Brief, PHM Exchange, PHM Charters translation and Media have failed consistently in spite of efforts in 2002

through a paper on communications as if people mattered and efforts in January 2004 (IHF) to circulate a paper on communication challenges. Recently however after Cuenca PHA2 due to the enthusiastic young Bangalore based website volunteers, a website linked communications circle has been established bringing together all the website managers and editors of an increasing number of global and regional and country level websites which have a strong PHM linkage or content.

ix. IPHU at PHA2 has resulted in three potential circles of IPHU student volunteers in the areas of Trade and Health; PHM experiments; and Social Determinants of Health. These are evolving slowly.

Policy on Issue Circles / Campaigns

- A time has come to move beyond this sort of adhoc circle formations that wax and wane with activities to the evolution of certain guidelines or framework for issue circle convenors in terms of communication / organizations / links to exchange / website and other structural / functional imperatives so that issue circles become a more visible and a more effective form of PHM growth and evolution.
- The Website and the PHM Exchange should be the key vehicles through which issue based activities in PHM are communicated and new members are constantly invited / encouraged to join in. This will greatly increase the value and meaning of PHM membership.
- Another important policy guideline is to decide when an issue circle becomes a campaign? A campaign must have some core objectives, methodology, an advisory and decision making structure, a time schedule and perhaps some funds of its own

5. FUNDING AND FINANCIAL MANAGEMENT

This was a major challenge and learning experience for us.

i) The PHA1 funding strategy had successfully managed to raise adequate resources from two types of funding partners during the pre PHA1 mobilization strategy.

   a) Government – social and health development funds – Dutch, UK (DFID), Finland (FINIDA), Belgium, and Sweden (SIDA).
   b) Funding agencies (NGOs) like DHF – Sweden, Oxfam, Bangladesh, WSM Belgium, Int. Solidarity Foundation, Finland, Plan International and Rockefeller Foundation.
   c) The total amount mobilized was around 1,297,268 Euros.

ii) While most of this was used to support PHA1 organization and mobilization there was a balance leftover which was used to support the early PHM evolving activities in 2001 and 2002 This support was for mostly planning meetings and steering group meetings and some support to a few PHM resource persons to attend regional and international conferences to present and promote the Charter and encourage PHM mobilization in the region. Some of these balances were also used to support publication of the News brief and reprints of PHA1 related background documents (The Blue brown books and the Charter).

iii) From January 2003, when the PHM Secretariat began to function from Bangalore, the first thing that was done was to formalize a funding group consisting of both Qasem and Ravi the outgoing and incoming coordinators, Andy (since OWA had been facilitating and managing a PHM account in UK) and Olle, Prem, Maria and Bala who had shown interest and capacity in this area during the PHA1 mobilization.

iv) Through e-group dialogue, this group planned for funding and financial management of PHM during the years 2003-05 with two or three meetings over these years in London and Bangalore to review the funding situation and plan strategies for longer term sustainability.

v) These ideas / opportunities converted the ideas derived from the e-group discussions into project proposals submitted to specific funding agencies and initiated dialogue and follow up action.

vi) It soon became obvious that the funding climate had changed since PHA1, and Government related funds and also grants from larger International agencies needed proposals in logical framework that were SMART as well (i.e., with goals / functions that were Specific, Measurable, Achievable, Reachable and Targeted). Since the growth of PHM was not predictable in the same way as a more specific conference event or a immunization campaign or project etc., all efforts to try 'logical framework approaches' to 'project proposal' evolution failed (though we tried and submitted them to Dutch government and DFID considering them to be more responsive).

vii) Based on CHC's earlier experience, coordinator began a new strategy as an alternative option to large grant seeking nicknamed later the Friends and Neighbours Policy. What it entailed was identifying smaller funding partners and grant giving agencies that would consider supporting specific events, publications, initiatives or needs of PHM in solidarity with PHM goals. Since the grants would be small never more than 5-1000 Euros, the consequent paperwork and justification of the request / proposal etc., would also be minimized. Individuals in the PHM Network who knew these groups were encouraged to mediate, advocate or facilitate the discussion. Sometimes these agencies were already supporting the PHM members NGOs and all they needed was information on a genuine need or a strategic opportunity.

viii) At first, this seemed a risky approach – needing a lot of time and effort and correspondence but with the help of PHM members this approach was quite successful. From 1-3-2002 till 2-4-2005 we raised 213,065 Euros by this approach.

ix) Another approach linked to this Friends and Neighbours Policy was for the Secretariat coordinator to write letters to different regions and founding networks to raise some regional / own travel support or contribution for every PHM need, event or initiative. This approach also got a good response and many regions like USA, Europe, Australia and even Asia and Middle East and many networks like IPHC, WGNRR and ACHAN always responded positively and so the PHM's financial burdens were shared.

x) This policy began to work quite well resulting in PHM Secretariat being able to ensure much larger participation and inputs in terms of funds and PHM resource persons in every PHM event / initiative – more than the PHM funds could make possible. This process was particularly successful in events such as the annual World Health Assembly and the World Social Forum events. At WHA, there were often 20-30 PHM participants with PHM secretariat having raised direct travel support for 3-5 people only.

xi) Another complementary aspect of this Friends and Neighbours policy was the secretariat's efforts to make WHO, GFHR and other such international health agencies to invite PHM related resource persons to WHA / GFHR meetings and support their travel and per diems – reducing the overall burden on PHM funds.

xii) This method became well established and the PHM external evaluation in June 2004 noted it as one of the strengths.

xiii) The same policy was extended to the PHA2 funding and while over 30 groups supported PHA2 finally the most significant aspect of PHA2 funding was that unlike PHA1, where most participants were supported by travel grants (excluding the Indian and Bangladeshi contingents) in PHA2 less than a 100 participants were supported with travel grants raised by the Secretariat. Over 1400 participants supported their own travel. The PHA2 organisers also raised lots of local support and solidarity from the University and local groups and this greatly reduced the costs. PHA2 was as large an event as PHA1 but was made possible at a fraction of the cost exemplifying the growing strength / capacity of the movement and the capacity of the

PHA2 / IOC and the region (congrats Arturo and Maria). For PHA2 we raised only 317,996 directly but nearly a million dollars totally if we include local / regional fund raising

xiv) An overview of six years of PHM funding experience (see table A and B) shows these trends:

PHM / PHA Funding 2000 – 2006 – An overview (In Euros)

Sl No.	Events	Period	Amount	Percentage
01.	PHA 1	01.10.98 to 01.03.02	12,97,268.00	70.95%
02.	PHM	01.03.02 to 26.04.05	2,13,065.00	11.65%
03.	PHA 2	26.04.05 to 16.01.06	3,17,996.00	17.40
Total			**18,28,329.00**	**100%**

Source: Supporters of Peoples Health Movement, OWA, UK

PHM / PHA Funding 2000 – 2006 – An overview (In Euros)

Events	Government	Percentage	Friends/ Neighbours / NGO's	Percentage	Total	Percentage
PHA 1	7,23,289.71	55.75%	5,73,978.29	44.25%	12,97,268.00	100%
PHM	61,917.90	29.06%	1,51,147.10	70.94%	2,13,065.00	100%
PHA 2	1,20,875.09	38.01%	1,97,120.91	61.99%	3,17,996.00	100%
	9,06,082.70	**49.56%**	**9,22,246.30**	**50.44%**	**18,28,329.00**	**100%**

Source: Supporters of Peoples Health Movement, OWA, UK

i. Decreasing government support and increasing solidarity support from Friends and Neighbours.

ii. PHM / PHA2 were managed on shoestring budgets quite different from PHA (in this a strength or a weakness!!)

Further analysis of this will be done after the audits of the three secretariats are completed by 31-3-2006.

xv) The Friends and Neighbours Policy has shown that it is possible to raise funds without strings and without following donor driven agendas or exploring donor driven band wagons. But this is still risky and needs a lot of effort – often stressful and sometimes quite frustrating.

Towards a Funding Strategy for 2006 and beyond

Perhaps a combination of strategies – tapping some revenue streams around specific PHM initiatives like Website, Global Right to Health Campaign, IPHU or for large events like PHA3 need to be followed up separately while the Friends and Neighbours policy should supplement these focused efforts for smaller needs.

As of January 2006, PHM has the following organizations / agencies as a potential consortium of supporters.
SIDA (Sweden), CIDA- Cordaid, Misereor (Germany), Cordaid (Netherlands), DFID (UK), Action Aid (UK and Asia, Africa), Christian Aid (UK), World Council of Churches (Geneva), AIFO (Italy), WEMOS (Netherlands), Medico (Germany), Hesperian Foundation and Doctor for Global Health (USA), MDM (France),DHF (Sweden), WHO-HQ, PAHO and other regions, WHO-CSDH, GFHR (Geneva), Save the Children (UK), Novib (Netherlands). Most of them, if they were approached would continue to be a PHM friend and neighbour.

Some would prefer to support certain regional needs rather than global needs. Many have regional desks separate from global desks and so can be tapped at two or three levels – central, regional or country level.

With regional coordination as the way ahead there is need to increase fund raising capacity at the regional level for regional needs, events, initiatives as well as raise support for travel and other costs for regional resource persons and participants to attend PHM global events and initiatives.

The recent discovery of over 12 PHM related websites at regional and national level – none of which require any PHM central subsidy is an excellent example of regional resource capacity mobilization.

Many of the consortium of supporters mentioned earlier would be very happy to support regional rather than global needs.

The challenge for the next phase of PHM development in terms of funding is to

- balance project funding and Friends and Neighbours policy of fund raising
- tap into growing consortium of potential PHM partners at global and regional levels
- build regional fund raising capacity
- ensure that at no time does funding or donor driven agenda become a constraining factor in PHM evolution by always promoting more decentralized, plural and local efforts.

6. SOME STRATEGIC THRUSTS

The Bangalore phase of PHM movement evolution has seen six strategic thrusts that go beyond governance, vision, action, funding and communications. These thrusts were seen as crucial to long term sustainability and to the celebration of diversity and plurality of this unique movement.

a) Rebuilding Bridges

The first People's health Assembly had been a great experience of organizing a multi cultural, multi-regional, people's dialogue effort with creativity, competence and a solidarity building ethos. Inevitably however the organizing group and many of the supportive members had experienced the stresses and stains of such a multi dimensional decision making effort leading to breakdown in some post PHA1 communications, reduction in enthusiasm levels of many participants and supportive networks and NGOs, crossed communication and some degrees of exhaustion, and unmet expectations. As a relatively new member in the global planning group, CHC had the unique experience of not being easily identifiable as linked to these past conflicts and dimensions. As we discovered them along the way, accidentally or through participant feedback and communication, we took very personal and proactive steps to help heal these feelings by encouraging participants of PHA1 with such mixed or negative feelings or experiences to appreciate the larger inspiring reality of the evolving PHM and to get involved with the movement in newer and more creative ways transcending the negative experiences of the past. Without listing such individuals / groups for obvious reasons – one of the nicest experiences of the secretariat team was to see nearly all such people back to work with PHM and strongly involved in PHA2 (healed, enthusiastic and actively contributing at local, national, regional or even global level). We believe that this was a crucial contribution and a lesson for the future as well as we track the post PHA2 scenario which would have had similar experiences.

b) Mobilizing newer and more youthful leadership

Another effort on our part was to identify and support / facilitate newer and often younger leadership in PHM so that the movement was more sustainable and not over dependent on the 'networkers' and 'activists' of the pre 2000 AD era. While respecting the contribution of these elders and their radical perspectives and recognizing the need to keep them involved as advisors, 'perspective builders' and 'inspirers', efforts were made to give newer resource persons (who were less well known globally / regionally but showed great potential capacity and enthusiasm greater opportunity to get more involved with PHM initiatives and take more focused responsibility for management and action. This was not an easy task because many of the 'activists' of the past are not always ready for this shift and have not always been developing younger leadership in their own areas of focus and influence.

However, our experience was very positive and we are very glad that as we transit to the next phase of global coordination, a large number of younger leaders are visible in all aspects of PHM activities. They need to be supported and encouraged in the next phase as well.

The presence of youth in all aspects of PHA2 organization and the effective IPHU experience bringing nearly 60 mostly younger activists were also symbolic of this trend. Efforts were also made to keep in touch with IFMSA, IPSA and other groups focussing on younger potential leadership. This whole process needs to be maintained.

c) Engagement with mainstream not only confrontation

Another major thrust in the PHM Secretariat's efforts since 2003 was to shift the focus of PHM initiatives from only confronting the main stream through protests, street actions and other modes of democratic dissenting – (which are very necessary because of the over dominance and cancerous spread of neo liberal economic and political determinism) to a more confident and more strategic process of engagement with the mainstream using strategic openings and opportunities (what may be called chinks in the armour) so that we built hope, enthusiasm and 'space for alternative thinking' even within mainstream institutions and the public health system. It was important not to remained confined to pre 2000 AD strategies of 'talking to the converted' or being preoccupied with micro level community based alternatives (the romantics of PHC / HFA) or becoming hopelessly cynical because of our perceived weakness, lack of resources or lack of recognition by the system.

Whether it was the advocacy with WHO, active involvement with WHA or the active participation in the GFHR fora or whether it was the PHM country relays that included meetings in the universities and with policy makers in every country visited, we consciously promoted the presentation PHM concerns, perspectives and Charters in mainstream institution and to policymakers with the confidence that 'evidence' was on our side. It worked to some extent at least especially in events related to WHA, GFHR, GHW releases, WHO-Health Systems Task Force and WHO-CSDH where we saw some results and impact.

d) Inspiring and informing 'evidence gatherers'

During the current phase, we have also attempted to take the PHM Charter to academic and research institutions so that mainstream institutions orient / inform their students about these perspectives and help to build up greater awareness among the future academic and researchers on the social determinants of health and the alternative socio-epidemiological analysis that is central to the People's Charter. Surprisingly, this effort has been more successful than earlier envisaged. The Charter is now recommended to students at the London School of Hygiene and Tropical Medicine, some of the Scandinavian Schools and other institutions. Mainstream journals have run articles by PHM resource persons. The presentations at the Annual Researchers Forum of GFHR and the Research Forum on People's Health preceding PHA2 are good examples of increasing interest in academics and 'evidence gatherers' in PHM concerns and analysis. The Global Health Watch report has been another such linking effort. Over 125 contributors to GHW1 included only 25 with a

direct PHM linkage and similarly the Latin American GHW brought together over 30 resource persons from the region in a collective evidence gathering exercise. The IPHU and the WHO-CSDH knowledge hubs in which PHM is very involved are all additional opportunities. If demand creators (activists) and system builders (academics and researchers) can begin to work together with respect and trust and a mutually acceptable alternative perspective, the movement would be strengthened at all levels.

e) PHM as Generic not Brand

This has been the most difficult but challenging proposition. To help PHM recognize all potential partners focusing on PHM as a generic process rather than getting too carried away by establishing PHM as an overarching brand. This has meant a policy of increasingly recognizing network and campaign groups at local, national, regional and international level as natural partners of PHM and not trying to make them members. This has been done by exploring linkages, common activities, co-sponsorship and collective action. PHM has met and worked with Oxfam, MDM, SCF, IBFAN, Environmental groups, IFMSA, various formations within the WSF arena and other groups at WHA, WSF and other events without too much hassle, encouraging groups to recognize PHM as a partner. This has also helped PHM visibility and outreach. A similar policy could be more actively followed at local, national and even regional levels. The challenge for maintaining this clarity between recognizing lower case – phm as spontaneous movements at every level and higher case PHM, which are initiatives / events sponsored by Global PHM will continue to be a healthy impetus for the growth and evolution of PHM.

7. DISAPPOINTMENTS AND CONTINUING CHALLENGE

While all the above thrusts began to make some impact and be accepted slowly by the PHM members at different levels, there were some areas in which the secretariat team remained disappointed because not much headway could be made. Perhaps this will continue to remain challenges to be addressed in the next phase.

a) The PHM website, communication and media efforts continue to be dominated by English and the English speaking world continue to be more involved in PHM because of this dominance. While a concerted effort was made to break this language divide by more Spanish-English efforts for PHA2 the language divide remains a challenge. It's not just a matter of communication but much more so the loss to PHM from the absence of cross cultural fertilization of ideas and creativity.
b) There is much more people/ community level PHM efforts often termed grass roots mobilization taking place at the initiative of local, community, district and sub-national PHM circles and members many parts of the world. However, the communication of these efforts at local / community level are not reflected adequately in our website, publication, reports – these appearing to be thereby focussed only on national and even more so with regional / international events and global levels of activity. Much more effort must be made to record / document the grass roots level of initiative

especially by harnessing younger volunteers to document them and perhaps more creative media efforts to focus on reporting them.

c) Enhancing responsiveness of the PHM participants in governance structures at all levels and enhancing representativeness of those participants will continue to be a great challenge. For PHM to be a more effective movement this internal democracy has to be constantly strengthened at all levels.

IN CONCLUSION

The next phase of PHM evolution and development post PHA2 will hopefully be a phase marked by greater representativeness and responsiveness of PHM structures, for governance, action and communication

i. a phase of greater rationalization, decentralization and regional and country level capacity building.
ii. A phase of greater maturity and strategy in our PHM initiatives for engagement and confrontation with the mainstream policy and system building efforts.

We must remember that PHM is fast becoming recognized as an Alternative to the Globalization of Health from above.

> As Harris and Seid in their latest Book on Perspectives on Global Development and Technology (Brill, 2004) have noted
> "the People's Health Movement (PHM) is clear evidence that the existing linkages between globalization and health are contestable.....
>
> ...The People's Health Movement and the People's Charter for Health provide a significant expression of alternatives 'from below' to the present globalization, privatization and commercialization of health among 'from above'.
>
> ...The People's Charter for Health lays out a blueprint for the transformation of the existing global circles through democratization at all levels of the existing system and through what some people in the global social justice movement call 'globalization from below".
>
> ...It is based on the assumption that global decisions must be demonstrated and that people's organizations and organized grass roots action can bring about an alternative vision of development –one that promote human and environmental well being. To achieve this vision, the PHM is pursuing the democratization of health decision and outcomes at all levels.
>
> ...One of the most strategic assumptions held by the PHM is that it will take organized grassroots action as well as concerted action at the global level to bring about the profound social changes that are needed to achieve the sweeping vision and radical goals of the movement.

The increasing recognition by the non-PHM world of the PHM world is a challenge to us as well as a great responsibility. Are we building the movement adequately to be responsive to such expectations? That is the continuing challenge before us.

In the Spirit of Allegremia (2006)

Abstract

The Transition Advisory Group (TAG) that met in Frankfurt from February 7th-8th February recommends a modified governance structure for the People's Health Movement. The TAG confirmed that the mandate of our movement comes from and is renewed through the People's Health Assembly. It recommends that between assemblies the organisation is steered by a steering Council (SC) (of no more than 20 people) representing our regions, networks and campaign areas. The Council would meet face to face once or twice a year and by email in between. The week by week work of the organisation at the global level would be managed by a small Coordinating Commission (CoCo) , effectively an executive board to the Council. The daily work of the organisation at the global level would continue to be carried out by the Global Secretariat, supported by a small number of functional coordinators (responsible for GHW, the website, WHO liaison, PHA3, fund-raising and IPHU)

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Minutes of Frankfurt Meeting

Full Report (for SG consideration)

The PHM Transition Advisory Group (TAG) met at Spenerhaus in Frankfurt on the 7th and 8th Feb 2006.

The group comprised: David Sanders, Claudio Schuftan, Prem John, Alexis Benos, Andy Rutherford, David Legge, Fran Baum, Maria Hamlin Zuniga, Hani Serag. Andreas Wulf and Thomas Gebauer of Medico International (MI) participated also. Ravi and Thelma Narayan, and Jihad Mashal were not able to be there. (Hani was a late replacement for Jihad.) The discussions in Frankfurt were facilitated by Fran Baum; David Legge provided electronic secretariat support as well as participating in the meeting.

The group reviewed a number of relevant PHM documents including minutes, reports and email discussions generated over the last 6-8 months plus a comprehensive report from the outgoing secretariat.

A detailed record of the discussions is available. The purpose of this report is to capture the essence of the conclusions and recommendations reached.

Mandate

The Transitional Advisory Group was commissioned at the SG meeting in Cuenca, 23 July 2005.

The Steering Group meeting in Cuenca discussed the Organsational Options paper from the Bangalore meeting (April 2005). A Transition Advisory Group was appointed to review the options for organisational development and 'evolve a framework of change'. David Legge, Andy Rutherford, Maria Zuniga and Thelma Narayan were appointed to this group.

Members of the SG (at Cuenca) made a number of further suggestions to help the small group in its organizational review and strategy development.

1. A smaller global decision making body with supportive working groups and clear roles;
2. Viable regions with regional coordinators and enhanced country level representativeness;
3. Clarification of the role of 'issue circles' and how issues become campaigns and how they can be included in PHM's worldwide programmes.
4. Accountability to the Assembly.
5. Blending regional and thematic representation.
6. National and sub-national mobilization to be emphasized in order to ground PHM at the grassroots and community level.
7. The organizational structure must be inclusive and responsive to help build the movement strategically.
8. Include a SWOT analysis of existing arrangements.

The Cuenca SG minutes record that the recommendations of this Transition Advisory Group would then be discussed with the SG and beyond to bring about a consensus on the

changes.

The Cuenca SG meeting also discussed two proposals for hosting the next global secretariat and adopted the following two decisions:

1. the process of identification of the next host of the secretariat and the coordinator should be by consensus and through a process that builds together and does not divide us.
2. Fran Baum was requested to receive both these and any other proposals within a month (by 23rd August 2005) and take such steps as needed to build a collective consensus and decision on what was most feasible.

The proposals and recommendations were to be circulated to all members of the steering group and a decision made before the end of September 2005 – so that a smooth transition from the India region (CHC, Bangalore) to the next region could be made.

Following the Cuenca PHA, Medico International offered to host a meeting in Frankfurt to take both of these discussions further. Further discussion within the SG across the email led to the acceptance of this offer and the identification of participants (as listed above).

Conclusions

Growth and its challenges for PHM

The movement is growing; the PHAExchange list has grown to 1900. We have an active presence in around ten countries; and are semi-active in another 20-30. We have been very well served by the outgoing global secretariat.

We have been welcomed in high places but we need to build a much stronger base in community health organisations around the world if we are to make sure that we are listened to and are truly representative. Are we being invited to the table because of the logic of our case and the power of our constituency or because our participation adds a patina of legitimacy to the deliberations of the establishment? Maybe both but we need to be alert to the latter.

Organisationally, we face a number of challenges. Our decision-making needs to be more transparent, efficient and participatory; at all levels and in all fora.

While we are still a young organisation it is not too early to worry about regeneration and renewal. We must share our history, develop our analysis and welcome our future.

We have a strong value base and political program, expressed most clearly in the Charter but we are a broad movement and within we have a range of different perspectives on some issues. We must neither paper over such differences nor let them divide the movement; rather we must analyse the facts and the politics of such issues and learn to speak together about our differences and be as inclusive as possible in our discussions especially in terms of including the experiences and aspirations of the people who have yet to achieve their right to health.

We come together, women and men, different countries, different cultures, different languages and different abilities. Our diversity is a threat but also an opportunity. We need

to find the structures and ways of working that are more inclusive and responsive; learning by listening; building the movement locally and regionally as well as globally.

The neoliberal analysis is in crisis. Every week there are more publications in scientific journals giving negative evaluations of neoliberal health reform; critiquing core elements of the neoliberal program; describing positive examples of primary health care. The Empire is in crisis; it is a moment of heightened risk but full of opportunities.

What sort of organisation is PHM

PHM brings together two separate entities: the People's Health Movement (upper case) and the people's health movement (lower case). PHM (upper case) is an organisation which has set itself the task of contributing to the development of the people's health movement (lower case) and to the achievement of the goals which define the people's health movement (lower case).

The people's health movement (lower case) comprises those organisations, individuals and communities of interest who are working on health related issues (at all levels) and who are struggling to give voice to the unheard; to develop health systems that work; redress inequities in access and power; to counter insecurity and exclusion and to strengthen the accountability of governments and donors. These organisations, individuals and communities constitute a 'movement' in so far as there is a generally shared sense of direction and a certain collective consciousness and solidarity. This is the 'movement' which PHM (upper case) seeks to support and participate in.

Clearly the effectiveness of PHM depends upon its relationship with the phm and we need to have a clear analysis of our relationships with the people's health movement and a clear sense of how that relationship will develop.

This framework points to a number of critical questions which will be answered by the way we organise ourselves, by our practice and in our culture. They include:

- accountability and responsiveness of the PHM to the phm;
- accountability of activists and volunteers within PHM;
- trust, expectations, rights and responsibilities;
- nature of our relationship with 'affiliated' organisations.

These are issues which we must keep talking about, at all levels in the organisation and across the movement.

Recommendations

Directions and principles

We must:

- decentralise and regionalise;
- harness our diversity;
- build our capacity;

- sharpen our critique;
- build our geographical circles;
- widen our network linkages;
- develop our thematic strengths
- listen to the experiences and aspirations of our different communities
- develop our organisation through action.

Broad framework: structures and relationships

We propose the following model:

> Our organisational mandate comes from and is renewed through the People's Health Assembly. Between assemblies the organisation is steered by a Council (of no more than 20 people) representing our regions, networks and campaign areas. The Council meets face to face once or twice a year and by email in between. The week by week work of the organisation at the global level is managed by a small Coordinating Commission, effectively an executive to the Council. The daily work of the organisation at the global level is carried out by the Global Secretariat, supported by a small number of functional coordinators (responsible for GHW, the website, WHO liaison, PHA3, fund-raising and IPHU).

This model is sketched in Figure 1 and Figure 2 below. More detail about our vision for these structures is provided in Table 1, below and in the following narrative.

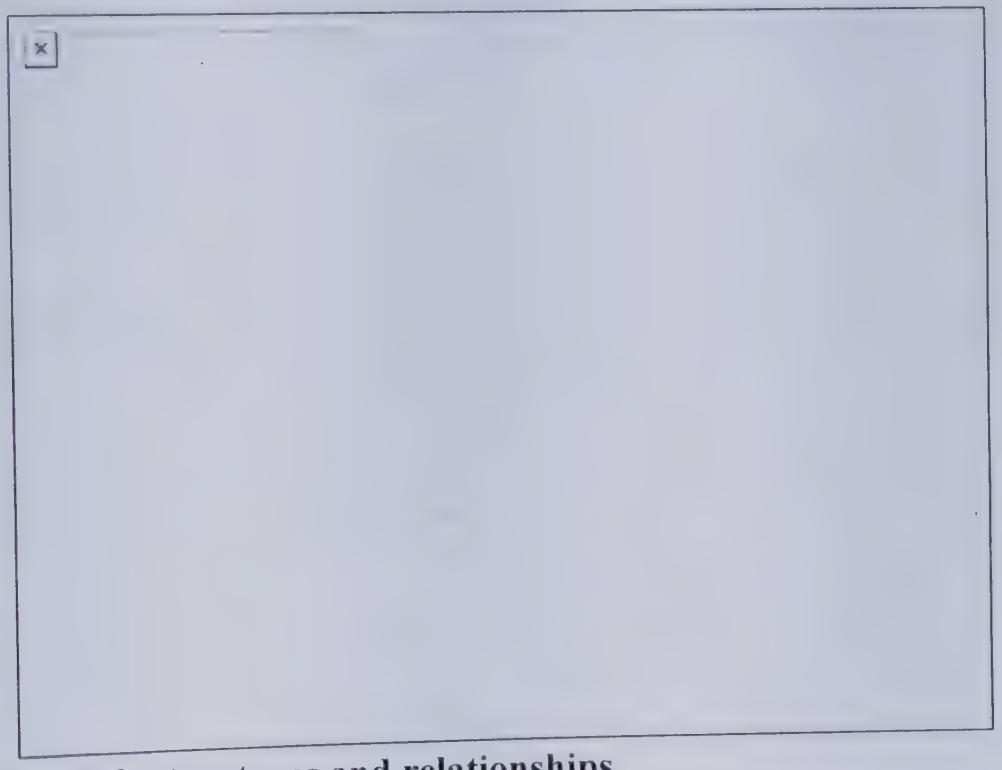

Figure 1. Draft model: structures and relationships

Assembly

Our organisational mandate comes from and is renewed at the People's Health

Assemblies. We expect that these will remain relatively infrequent, perhaps every five years in the short to medium term. At least one half day of each PHA should be committed to reviewing and renewing the stewardship of the Steering Council of the PHM. We recommend that at this session delegates from active national PHM circles and from affiliated global networks be formally recognised for voting purposes but other PHA participants would be welcome to attend this session also.

We do not recommend an election process from Assembly to Steering Council because we think that for the foreseeable future the Steering Council should be comprised of regional representatives and network and thematic representatives. How regional representatives are selected may vary between regions and regional representation will need to be renewed more often than once every five years.

Steering council

The main direction setting body between PHAs should be a Steering Council with representation of 'regions' and networks. We felt that it might be sensible to give this structure a different name from the Steering Group that has existed since Savar and suggests the terem Steering Council. We think that the numbers on the SG should be restricted to 20 or fewer.

As shown in Figure 1 the Steering Council would have a formal relationship of report and accountability with a formal general assembly at each PHA.

Coordinating commission

We recommend a small coordinating commission accountable to the larger Steering Council, serving as a kind of executive to the Steering Council and working closely with the Global Secretariat and functional coordinators (eg web coordinator, fund-raising, etc).

Size. We recommend that the Coordinating Commission comprise seven members including the Global Coordinator as one of the seven.

Term. We propose that the term of office of the first CoCo be one year. At this stage we are planning for the interim coordinating commission which will have the job of overseeing the implementation of these recommendations and bedding down the new global secretariat. One year should be enough to complete this. There should be a formal review of progress preferably at a full Steering Council meeting at around six months from the date of the adoption of recommendations arising from this report.

Mandate. The mandate of the Interim Coordinating Commission will be:

- manage the transition (preferably within six months but certainly in no longer than one year),
- serve as executive board to SC,
- manage the public representation of PHM globally (with the Global Coordinator),
- manage regional liaison and capacity building,

- ,manage, endorse and monitor thematic circles (issues, campaigns projects)
- manage functional coordination of the movement.

We envisage a portfolio responsibility system in the Interim Co Co including allocated responsibilities for the transition and development process; for fund raising and for the development of regional and national circles.

Membership. We suggest the following as members of the Interim Co Co:

- Fran Baum and Prem John (both with special responsibility for transition the) - agreed
- Global coordinator (or representative of secretariat) - to be identified by collaborating regions
- David Sanders representing Africa (PHA3 and GHW) - agreed
- Arturo Quizhpe &/or Margarita Posada and Nadia van–der Linde were proposed, have been approached and are considering the issue and we hope to have their response soon
- Ravi (as retiring global coordinator, with particular responsibility for regional capacity building) - agreed

Functional coordinators. Andy Rutherford (finances) and David Legge (IPHU) would also be expected to attend. David Legge agreed to work with the new secretariat to create an intranet site to archive and access key documents. His document organisation played a valuable role in supporting the efficient running of the Frankfurt meeting.

Chair. We expect that the Chair of the Co Co will be identified by the SC. In the first instance we recommend that Fran & Prem serve as co-chairs of the Interim Co Co. The global coordinator (or secretariat representatives) will not serve as chair.

We propose these names for the Interim Coordinating Commission but in future the membership of the Co Co would be nominated by the SG based on individual capacity, organisational representativeness, main organisational functions and leadership. It would have a link with the preceding secretariat, in the early period post transition and then with the succeeding host region in its latter period.

Global secretariat

The MENA group is presently working on a proposal for global coordination based on a regional collaboration involving PHM circles in Egypt, Lebanon and Palestine. It is not yet clear who would be the lead group and where the secretariat would be physically based. A MENA planning meeting, with members of this Transition Advisory Group, is scheduled for 25-26 Feb in Cairo.

MENA is proposing that the global secretariat will work closely with the functional coordinators, ie the web, GHW, fund raising, IPHU, and the next PHA.

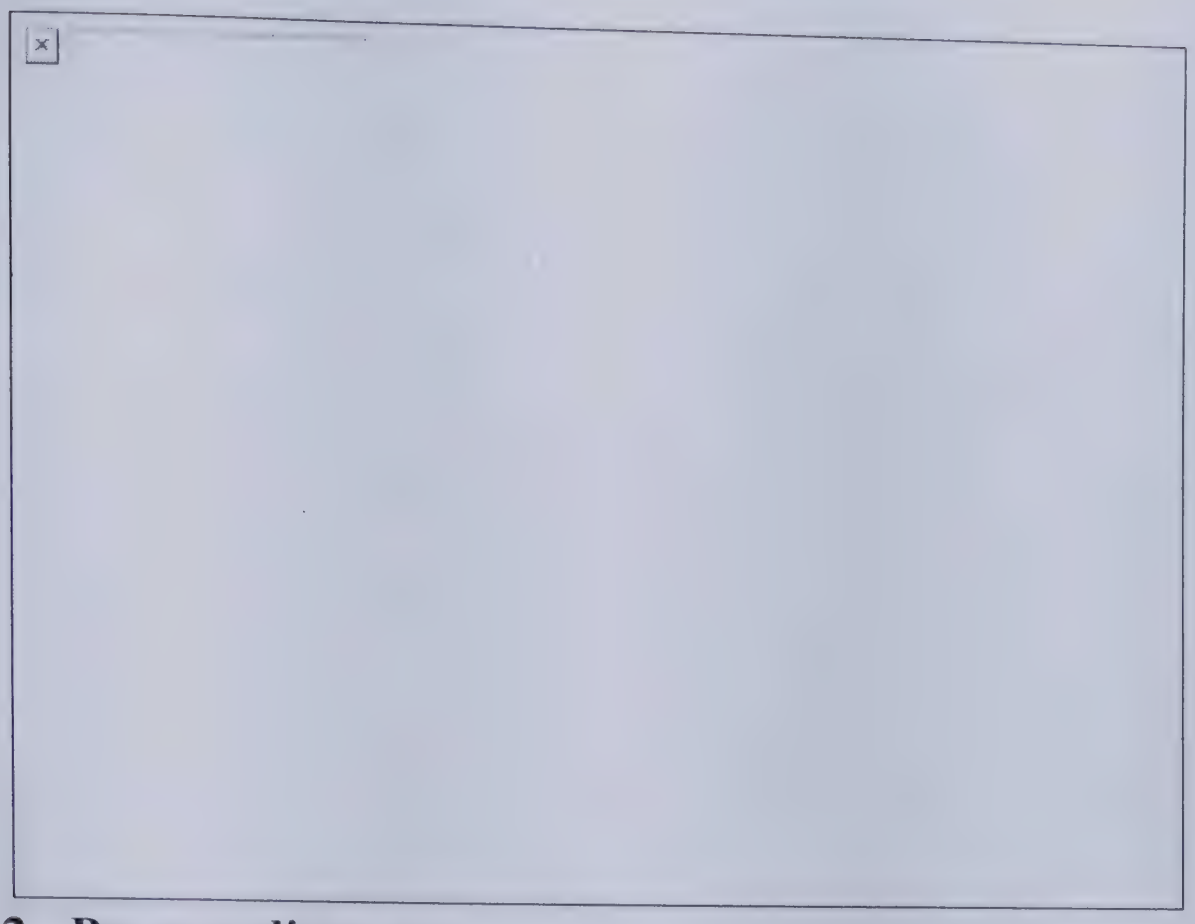

Figure 2. Process diagram

Entity	Functions	Accountabilities	Composition	Next steps
Assembly	set broad directions for the movement provide guidance to SC	to the appointing constituencies in countries and networks	delegates from national PHM circles and affiliated global networks	guidelines will be needed to accredit national and network delegates also guidelines regarding conduct of Assembly

Steering Council	strategic directions (incl campaign commitments)	to Assembly	10-13 regional reps ~4 coopted thematic reps < 3 coopted global network reps some (~3) or all functional coordrs	criteria for inviting global networks and thematic circles to join SC guidelines for regions to be actively represented (activity) guidelines for appt and recall of regional reps start with active regions (see below)
Coord'ing Comm'n (7 people) • from SC membership • with managerial and political skills • 'balanced' (gender, age, language, region)	manage transition (resp of interim CoCo) 'executive' body spokes manager regional liaison and capacity bldg manage, endorse, monitor thematic circles, projects, campaigns week by week management manage functional coordination guide global secretariat progress internal democracy	to Steering Council	elected/ appt'd/ volunt'd from Steering Council membership ? regional reps (?2-3) ? retiring coordr / coordr elect (?limited term) ? (some) functional coordrs ? (key) thematic leaders ? one year appt for interim membership	more definite guidelines needed for renewal of CoCo after one year

Global Secretariat	communications support to Council and Commission regional liaison budget development and management spokespersons management records eg develop list of affiliates	to CoCo and SC	based in MENA supported by Egypt, Lebanon and Palestine include close links with functional coordrs include recently retired global coordr	MENA to finalise its preferred model for supporting the secretariat function; meeting in Cairo scheduled for 25 & 26 Feb
Functional coordrs • fund raising • website • communications • GHW • WHO liaison • IPHU • PHA3	manage respective functions	to CoCo & SC	appointed/ endorsed by SC?	
Regional coordinating structures includes regional functional coordrs	See below	to national circles and up to Steering Council	will vary according to the stage of PHM development	annual meetings need to develop guidelines
Thematic Circles (issues, campaigns)	topic investigation / lobbying / advocacy / campaigning	to Charter to CoCo to SC, to regional & national circles	ranges from commissioned circles to endorsed circles some of these are undertaken in alliance	guidelines re issues criteria for campaigns
National /provincial coordinating structures	see Charter	local communities	emergent as needed	guidelines needed

Table 1. Structures, memberships, functions, accountabilities, next steps

Regions

Regional boundaries for the purposes of representation of national PHMs on the SC and for mediating communication will inevitably appear arbitrary from some perspectives. On the other hand it is not possible to have direct representation of all national PHM circles on the Steering Council.

We recommend that the following thirteen regions be adopted for representation on the SC. We recommend that the 10 active regions be represented on the SC in the present period but as the remaining three become more active they will also be invited to nominate

representatives to the SC.

1	East Africa	✓
2	West Africa (covered by Southern Africa in interim)	?
3	Southern Africa	✓
4	Europe	✓
5	MENA	✓
6	India	✓
7	South Asia	✓
8	LA & Caribbean	✓
9	USA & Canada	✓
10	East Asia (covered by SE Asia in interim)	?
11	South East Asia	✓
12	China (covered by SE Asia in interim)	?
13	Australia, NZ and Pacific	✓

Table 2. Proposed regions. Ticks indicate immediate representation on Steering Council.

Regional representation on the SC should be linked to certain criteria, primarily about regional activity. Perhaps also the number of active countries; eg at least two countries with functioning national circles; with local links. Criteria will be needed to evaluate 'level of activity' for the purposes of SC representation.

There needs to be a transparent process for selection/election/appointment of regional representatives and recall in cases of non-performance. We need to have clarity regarding the obligations associated with the role. These include: serving as link person (between national and global); contributing to SC; participating in fund-raising across their region; communicating up (to the global sect) and down to the local. Regional reps will reflect local circumstances. We propose a maximum of two terms of office each of three years. Their replacement should be staggered to maintain continuity.

It could be helpful to replicate elements of the global portfolio structure in each region, including functional link persons and thematic and network links. This is a matter for regions to determine.

Networks

Representation of other NGO networks on the SG should be based on agreed criteria, for example, criteria about their global reach, about their identification with the PHM, and their adding value to our work.

There are probably a range of groups that we can identify now that would add value to the work of the SG, eg WABA, IBFAN, WGNRR.(already a member of current SG), WSHF, IFMSA

Issue circles, projects and campaigns

These activity areas vary widely. The organisational requirements to support issues circles are different from those required for projects and campaigns. Some campaigns are sponsored by an alliance of organisations, some mainly through PHM. Some are time limited; some ongoing.

It is important to differentiate between issues, projects, campaigns and organisational functions. Issue circles have autonomy but campaigns in the name of the PHM need to be approved and accountable. This approval or endorsement process needs to be more streamlined. One of the responsibilities of the Coordinating Commission will be to have some kind of global framework to guide it in endorsing statements and launching and monitoring campaigns. Coordinating Commission should take responsibility for the oversight of the big ones; the issue circles with global reach.

The new structures need to support activity and effectiveness. Global campaigns such as the Global Right to Health should be endorsed by the SC but once it is approved its oversight passes the to Coordinating Commission who have to make sure that it is carried out. These responsibilities have implications for the operations of both the SC and the Coordinating Commission (record keeping, communication protocols, etc). Perhaps someone in the Coordinating Commission needs to have portfolio responsibility for ensuring following up on campaigns and circles and issues.

It may be useful to identify some thematic and functional areas as core as distinct from non-core. It would be good to have link persons at the regional and national levels in relation to core activities (such as GHW, RTH, IPHU).

Implementation

This draft of the TAG report will be endorsed as amended by all of the TAG members and then circulated within the SG for discussion, amendment and endorsement and then communicated to the PHA Exchange List.

Fran and Prem are authorised to report to the SG, respond to queries and seek SG endorsement. This process should take no longer than two weeks. Fran and Prem then finalise a paper for distribution through PHA-Exchange (and other relevant lists) and commence implementation.

The implementation schedule following approval by SG will include:

- fund raising;
- start up of the Interim CoCo;
- preparation of draft guidelines, criteria, norms etc;
- regional action to elect SC members;
- opening of new Secretariat Office.

We have identified a number of issues around which PHM needs explicit guidelines (criteria, norms, rules etc) which will need to be worked on by the Interim Coordinating Commission. (Some of these are listed in the 'next steps' column of Table 1, above). However, while rules and guidelines are necessary they must live in the culture of the organisation. Having them written down is meaningless if they are not reflected in our routine discussions (if they do not reflect our routine ways of doing things).

Capacity building: developing the regions; developing national and local PHMs

A concerted program of development work is needed to develop PHM at the local, national and regional levels. Some possible strategies include:

- visits and speaking tours;
- working closely with people at the grassroots
- opportunities to exchange experience across and between different country and regional circles
- having national and regional link people in relation to global functions such as GHW, IPHU, RTH
- action around particular issues, campaigns, projects; not just talk;
- build from the Charter; what does it mean at the neighborhood and local levels;

We need opportunities to share strategies and experiences; case studies of experiences; this is our richness; something that is inspirational.

Build links across the movement; use the website; open a circle; use mobile phone videos; useful resources can take many different forms.

IPHU should include a focus on experience sharing in the building of PHM.

PHA 3

Planning for PHA3 should start now. Preparation should be done in ways which are capacity building for country circles; building the program; identifying the delegates, etc.

We have much to learn from previous assemblies. We need an Assembly Planning Manual (checklist) by the end of 2006.

Fund raising

PHM has been quite successful in fund raising over the last six years and these monies have been used very effectively. Nevertheless the movement is in debt and urgently needs a new approach to fund raising.

We cannot expect large operating grants from global donors. We need to focus more on regional fund raising and to develop the 'friends and neighbors' approach; many small dispersed donors should be approached through personal relationships rather than relying on the Big Donors. The F&N approach involves lots of relationships; more private rather than

public.

Regional and national development will be a strength in fund raising but we need to be well coordinated in our fund raising approaches; eg not to go to the same organisation as two different groups.

We need a clear forward looking plan for PHM that we can take to people and say this is what we will do over the next few years. We need a presentation of ourselves over the next period; not slick but strategic. It should list the activities which are foreshadowed and a budget. A well articulated, convincing, statement of our aspirations, our plan, a background document to support more focused funding applications.

We need to include our global overheads in all requests for funding. If we are planning for a workshop on a specific theme we need to include provision for overheads for global resourcing.

We need a budget for the global secretariat.

We need a list of activities to be initiated over the coming year and agree who is going to write the proposals. We need to push for decentralisation of fund raising. Everyone must do the fund raising.

Project funding is easier to find than funding for network development but we must be careful not to "projectise" the PHM. We need to be able to show how the general network is necessary to achieve the full value of the various projects. We need to speak clearly about the role of the Global Sec't as adding value to the more focused projects. Be careful where the projects have a coalition base.

The multiplier function will be attractive to funders. While the total cost of the Cuenca IPHU Short Course was around $180k only around $30k was formally donated to make it happen. The rest was in-kind support, leveraging donor funding.

We need to look at income generation as well as donor support.

We need a series of component documents which can be put together as needed:

- expenditure budget for running the secretariat, the CoCo and the SC;
- background documents about PHM generally that can be used in various fund raising ventures;
- strategic plan, outlining of where we are planning to go in the near to medium term;
- a flexible revenue budget, setting out, in order of magnitude terms, the funds which will be needed to be raised as overhead funding from more focused activities;
- a clear fund raising strategy.

The new global secretariat and Interim CoCo will need to give priority to preparing these documents and implementing a broad fund raising strategy using these documents.

Winding up

The Transition Advisory Group acknowledges with appreciation the vision of Medico International in supporting the meeting.

Appendix. Actions, Responsibilities and Timelines

22 Feb	Transition Advisory Group submits report to Steering Group	Fran & Prem
25-26 Feb	Cairo meeting of MENA with TAG reps	Hani & Prem
early March	SG adopts, as amended, the TAG report as the basis for the Transition, including membership of Interim CoCo. Decision broadcast on lists	Ravi
late March	CoCo starts work	Fran & Prem
July 1	New MENA-based Global Secretariat open for business	MENA
July-Oct	Regional meetings	
~ Dec 2006	First meeting of new Global Council	Interim CoCo
2010	PHA3	David Sanders